



## Provider Course Registration Form

Participant Information																
Full Name:	Provider Type (circle type): EMT-P CRNA LPN RN NP PA MD DO Other _____															
Address:	License # & state licensed in:															
City/State/Zip:	Hospital Affiliation:															
Email address:	Name as you wish it to appear on name badge:															
Telephone #:	Special Meals: ( ) None ( ) Vegetarian ( ) Kosher ( ) Low Fat ( ) Other (explain) _____															
Course Information																
Location:	Date:															
Provider Course Manual (select a format): <input type="checkbox"/> Printed format: Volumes 1, 2, & 3 (~1300 pages) <input type="checkbox"/> Print/CD combination format: Volume 1 print format (350 pages) + Volumes 1-3 on CD-ROM	Ship my Provider Course Manual to this address:															
<i>Would you like to register for the Trauma Module offered with this course (if available)?</i>																
How did you hear about CALS and what interested you in taking the CALS Provider Course?																
Billing Information																
Select a payment option: <input type="checkbox"/> Check # _____ <input type="checkbox"/> VISA* <input type="checkbox"/> MASTERCARD* <input type="checkbox"/> Send an Invoice to me  <i>*complete card info at right</i>	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr style="background-color: #cccccc;"> <th colspan="2" style="text-align: left;">Card information</th> <th style="text-align: left;">Billing Address</th> </tr> </thead> <tbody> <tr> <td colspan="2">Name as it appears on card</td> <td>Address line 1</td> </tr> <tr> <td colspan="2">Card #</td> <td>Address line 2</td> </tr> <tr> <td>Expiration date (MM/YY)</td> <td>3-digit security code</td> <td>City, State</td> </tr> <tr> <td colspan="2">Amt to be billed to card</td> <td>Zip code</td> </tr> </tbody> </table>	Card information		Billing Address	Name as it appears on card		Address line 1	Card #		Address line 2	Expiration date (MM/YY)	3-digit security code	City, State	Amt to be billed to card		Zip code
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Card #		Address line 2														
Expiration date (MM/YY)	3-digit security code	City, State														
Amt to be billed to card		Zip code														
Contact Information of Person Completing This Registration if Other Than Registrant																
Name:	Hospital Affiliation:															
Email address:	Phone #:															
Instructions																
Return completed registration form to the CALS Program via US mail or facsimile transmittal: US Mail: CALS Program, 717 Delaware Street SE, Suite 508, Minneapolis, MN 55414 FAX: (612)626-2352																