ALLIED HEALTH ON-SITE REGISTRATION

PERSONAL INFORMATION

Please print clearly. **denotes required field*

*Degree ☐ RN ☐ LPN ☐ COT ☐ COMT ☐ COA ☐ _____ ☐ _____ *(Check all that apply)*

_____

*Full Name

_____

*Address ☐ Home ☐ Work

_____

*City *State *Zip

_____

*Phone Number (cell/home) (fax)

_____

*Email Address

☐ Ophthalmic Technician ☐ Ophthalmological Nurse ☐ Other_____

Course location: The Conference Center at Apple Mountain
4519 N. River Road
Freeland, MI 48623
For directions, please visit:
https://www.applemountain.com/directions

☐Registration Fee: $50.00

Make checks payable to: UM Dept of Ophthalmology and Visual Sciences

CREDIT CARD PAYMENT: ☐ American Express ☐ MasterCard ☐ Visa

Cardholder Name: _____

Card Number: _____

Expiration Date: _____ 3 or 4 digit code: _____

Signature: _____

Not valid without signature