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: North Campus Research Complex - Research Auditorium
2800 Plymouth Road
Ann Arbor, MI 48109
For directions, please visit:
https://ncrc.umich.edu/maps-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