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: Kellogg Eye Center
1000 Wall Street, Ann Arbor, MI
6th Floor Education Conference Room
For directions, please visit:
www.umkelloggeye.org/our-locations/kellogg-eye.html

☐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