TRAINING CENTER Registration Form

Name:	
Mailing Address:	City: State:
E-mail Address:	Professional License #:
Work/Dept.Phone:	Cell/Home Phone:
Health First Associates Universal ID (Required) # ______________________________________	
Non-Associates Birth Month ___ ___ **Birth Day** ___ ___ **Last 4 digits of SSN** ___ ___ ___ ___ **Required** (information used for databasing purposes only)**:**	

Course Name(s) and/or Textbooks	Course Date(s)	Fee

Payment options are as follows and payment must be submitted with this registration form:

Select One (X)	Description	Amount Due
	Cash, Check or Money Order (Made Payable to HF Training Center)	
	Credit Card (MC, Visa, Discover): # ____________________________________Exp. Date:_______________	
	Health First Associates Only-Payroll Deduction : I authorize Health First to deduct over ___One ____Two ____Three pay periods until the amount indicated is paid in full.	

Cost Center Transfer:
(not available for CPR or ACLS)

Manager Signature:________________________________

Cost Center #:_______-_______________-_________

Send form and payment to Barbara Couch:

Mailing Address: Health First Training Center
3470 N. Harbor City Blvd.
Melbourne, FL 32935
E-mail address: barbara.couch@health-first.org
Phone: (321) 434.1972 Fax: (321) 254.0795

By signing this form, I agree my registration fee will be forfeited if I fail to cancel my registration within 48 hours of the start time of the course. A $10.00 fee will be charged to process all refunds.

If I elected Payroll deduction, I understand and agree that upon my severance of employment, whether voluntary or involuntary, any balance due for this deduction will be withheld from my final check and/or from pay out of accrued PL. Additionally, if this course is of no cost to me, and I fail to cancel within 48 hours as noted above, a $10.00 fee will be deducted from my paycheck.

Signature (Required) Date

Office Use Only: GL Account #050 600001 6405 52 - Training Center
Authorized by:_________________________ Date:___________________