

Course Registration Form

Please complete all sections of this form in CAPITAL LETTERS and return to AMS at least one week before the course starts to the AMS Training Department E-mail: training@advancedmedic.com Tel: (587)337-6222

Course Name:			
Date Requested:			
Title:			
First Name:			
Surname:			
Heart and Stroke ID			
Designation (RN,MD,EMT etc.)			
Organization:			
Billing Address:			
	Postal code:		City
Contact Telephone:	+ / /	Office Fax:	+ / /
Email: <small>*Please use same email as previous Heart Association Courses if applicable</small>			
Registration Fee:	<input type="checkbox"/> My Company will pay the participation fee (Indicate billing contact by email) <input type="checkbox"/> I Have enclosed the requested Fees		
Total Fee To be Invoiced: <ul style="list-style-type: none"> • Cash, Cheque or Money order Payments can be made at our training center at 233 Utsingi Dr Yellowknife. • Please make Cheques Payable to Advanced Medical Solutions 			
Payments (Circle One) <div style="text-align: center;"> <input type="checkbox"/> Cheque <input type="checkbox"/> Cash <input type="checkbox"/> Money Order <input type="checkbox"/> Visa or <input type="checkbox"/> Master Card </div>			
Name on Credit Card:			
Credit Card Number:			
Expiration Date:			

I Authorize AMS to Bill My Credit Card for the amount indicated above if applicable

In accordance with the Canadian Laws on privacy, I the undersigned, authorize AMS to use the personal data received through this registration form for purposes relating to its activities.

Signed..... Date