



**Select Medical Outpatient Division
Clinical Education Department**
1794 N. Parham Rd, Richmond VA 23229
Phone: (804) 290-0107 Fax: (717) 635-3897

2011 Continuing Education Course Registration Form

Name _____

Profession: PT OT PTA COTA ATC SPT Other _____

Address _____

City _____ State _____ Zip _____

Phone Number: () _____ Cell Phone Number: () _____

Email Address _____

Course Name _____

Course Dates _____ Course Location _____

Please indicate if any of the above named registrant should be contacted regarding necessary special accommodations to ensure a satisfactory learning experience.

Course tuition cost is \$395.

Method of Payment (Circle One): Check MasterCard Visa American Express

Card Number: _____ Exp. Date _____

Signature _____

If paying by check, please make payable to "SELECT MEDICAL CORPORATION"

Please return this registration with payment to Erin Melton, c/o Select Medical Outpatient Education Dept., 1794 N. Parham Rd Richmond VA 23229 or via secure fax to 717 635 3897

For more information, or to register with a credit card by telephone, please call 804 290 0107.

Confirmation letters with additional course detail will be sent within one-week of registration receipt.

REFUND and CANCELLATION POLICY

Individuals who find it necessary to cancel may receive a refund, less a \$50 processing fee. To receive a refund you must submit written notification at least 7 days before the program date. The course sponsor reserves the ability to cancel the course in the event of circumstances beyond our control and assumes no responsibility for any non-refundable travel costs. In the event of cancellation, the participant will receive a full refund of course tuition fee.

FOR OFFICE USE ONLY	
___	Date Received
___	Date Returned