



College of  
**Professional and  
Continuing Studies**

## Registration Form

Select one:  Dr.  Mr.  Ms.

Date: \_\_\_\_\_

Name \_\_\_\_\_

Home Address \_\_\_\_\_ Apt/Suite# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

How did you learn about this course?  Catalog  Brochure  Email  Internet  Newspaper

Previous Class  Corporate Training Office  Word of Mouth

Company Name \_\_\_\_\_

Job Title \_\_\_\_\_

Daytime Phone ( ) \_\_\_\_\_ Alternate Phone ( ) \_\_\_\_\_

Fax ( ) \_\_\_\_\_ E-mail \_\_\_\_\_

Section Number	Course Title	Fee
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
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