

COURSE REGISTRATION FORM

This was previously submitted by: Fax Online Telephone Date: _____

(Please print or type all information. You may duplicate this form for multiple registrations)

Name _____
First Name Middle Initial Last Name

MD DO RN LPN RT RDMS RDCS RVT Other, Specify _____

Address _____

City _____ State _____ Zip _____ Country _____

E-mail (Required for Confirmation) _____

Daytime Telephone _____ Fax _____

Physician Specialty _____ Last 4 digits of Social Security No. _____

Sonographer/Specialist: College/Technical School _____

Please see prerequisites

Years of Allied Health Experience _____ Current Position _____

Course(s) Desired

Title(s) 1 _____ Date _____ Fee \$ _____

2 _____ Date _____ Fee \$ _____

3 _____ Date _____ Fee \$ _____

Total \$ _____

(U.S. Funds)

Payment Method

Check VISA MasterCard Wire Transfer (Required for Overseas Payment other than Credit Card)

Make checks payable to: **Wake Forest University Health Sciences-Ultrasound** for total amount (U.S. funds only) or complete credit card information.

If paying by credit card, please complete:

Card # _____ Expiration Date _____

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Telephone: 336.716.4505 or 800.277.7654 ext. 64505

E-mail: cmu@wfubmc.edu

Web site: www.wfubmc.edu/ultrasound

2009-2010

Mail or Fax to:

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Wake Forest University School of Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1039
Fax: 336.716.2447

Diagnostic Ultrasound

Courses, Seminars &
Educational Media