

Course Registration Form

Name _____

First Middle Initial Last

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 School of Medicine – Ultrasound** for total amount (U.S. funds only) or complete credit card information. If paying by credit card, please complete:

Card #

Expiration Date

Signature

Cardholder's Name

PRINT FORM

and

Mail to:

Program for Medical Ultrasound
Wake Forest School of Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1039

or

Fax to:

336-716-2447