Course Registration Form

Type your information below and submit by email / fax / mail

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

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

Fax to:
336-716-2447

Email to:
cmu@WakeHealth.edu