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REGISTRATION/REQUEST FOR INFORMATION FORM

Allied and Public Health Education
Continuing Education Calendar
Fall 2006

NOTE: **You must complete this registration form in its entirety to confirm your registration.**

SS#:__ __ __ __ (last 4 digits) Last Name: _____First Name: _____MI:_____

E-mail Address:_____ Degree(s) or Certification(s):_____

Discipline (Circle only one): Aging Allied Health Mental Health Nursing Pharmacy Public Health

Specialty/Occupation:_____

Employer:_____ Employer Address:_____

Department: _____Workplace Phone: ( )_____Home Phone: ( )_____

County of Employment:_____ Home Address:_____
(Street/PO Box) (City) (State) (Zip)

Prefer mail at: ☐ Office or ☐ Home

Registration for any program via mail, fax, or phone acknowledges your responsibility of payment.

_____ Register me for this program. _____ Send me more information about this program.

Program Title: _____

To register or request information for a program, copy this form and mail or fax it to:

Area L AHEC
Attn: Brenda Boykin
Post Office Drawer 7368
Rocky Mount, North Carolina 27804-0368
(252) 972-6958
(252) 972-0419 fax

Signature:_____