Course Registration Form

Type your information below and print to submit by mail or fax *or* **REGISTER ONLINE NOW ▶**

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