

MEDICAL ADVANCEMENT CENTER

REGISTRATION FORM FOR CE CLASSES

OFFICE (714) 952-8964

FAX (714) 527-1589

Name: _____

Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Professional License #: _____ (Necessary for CE Credit)

License Type: **LVN** **RN** **Other:** _____

Course Name	Date	Amount
Total Amount		
Enclose: Check / Money Order / Credit Card Information Mail To: MAC 4141 Ball Road, #204, Cypress, CA 90630 Fax To: (714) 527-1589 www.medadvctr.com		

CHARGE CARD PAYMENT

Circle one: **VISA** **MASTERCARD** **DISCOVER/NOVUS CARD**

Authorization Amount: _____

Credit Card #: _____

Expiration Date (mm/yyyy): _____

Card Holders Name: _____

Authorized Signature: _____