MEDICAL ADVANCEMENT CENTER

REGISTRATION FORM FOR CE CLASSES

OFFICE (714) 952-8964 FAX (714) 527-1589 OFFICE@MEDADVCTR.COM

Name: ____

Address: ____ Apt.# ___________

City: _________________________________ State: _____ Zip: _____________

Best Phone: ____________________ Alternate Phone: ______________________

Email: ____

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: 11041 Via El Mercado, Los Alamitos, CA 90720
Fax To: (714) 527-1589
office@medadvctr.com www.medadvctr.com

CHARGE CARD PAYMENT

Circle one: AMEX VISA MASTERCARD DISCOVER/NOVUS CARD

Authorization Amount: _________________________

Credit Card #: ________________________________

Expiration Date (mm/yyyy): _____________________ CVC Code: _______

Card Holders Name: ____

Authorized Signature: ____