TRAINING REGISTRATION FORM

NAME: _____
(Print clearly for certificate)

OCCUPATION:
_____

D.O.B: _____

AGENCY/ORGANIZATION:
_____

STREET ADDRESS:
_____
(AGENCY/ORGANIZATION OR HOME)

CITY: _____ **STATE:** _____ **ZIP:** _____

TELE: _____ **FAX:** _____

PREFERRED MAILING AND BILLING ADDRESS:
_____

EMAIL CONTACT:
_____

****COURSE TITLE AND DATE****:_____

AREA OF EXPERTISE:
_____

_____

NUMBER OF STUDENTS ATTENDING: _____

PLEASE PROVIDE MEDICAL BACKGROUND FOR ANY SPECIFIC LIMITATIONS IN TRAINING

_____

_____

PAYMENT TYPE (PLEASE CHECK ONE)

COMPANY/AGENCY CHECK _____ **MONEY ORDER** _____ **ORGANIZATION PO** _____

CREDIT CARD PAYMENT: VISA_____ **MC**_____ **AMEX**____ **DISC** _____

CREDIT CARD NUMBER: _____ **Exp:** _____ **Sec. Code:** _____

(SECURE LINKPOINT LINE)

Mail registration and payment to: **P.O. Box 6936, Piscataway, NJ 08854**
Payable to: **Awareness Protective Consultants, LLC**
If faxing registration and purchase order, please fax to **1-866-635-5761**

*****ANY RETURNED CHECKS WILL INCUR A CHARGE OF $35.00*****
*****FULL PAYMENT DUE UPON REGISTRATION FORM SUBMITTAL*****

CANCELLATION POLICY:

Student will receive full refund of fee if cancelled in writing 30+ days prior to course start date. All cancellations must be submitted in writing. Cancellations that are received after that will be responsible for full payment. **NO WRITTEN NOTICE - NO REFUND**