



TRAINING CENTER Registration Form

Name:	
Mailing Address:	City: State:
E-mail Address:	Professional License #:
Work/Dept.Phone:	Cell/Home Phone:
Health First Associates Universal ID (Required) # _____	
Non-Associates Birth Month ____ Birth Day ____ Last 4 digits of SSN ____	
Required (information used for databasing purposes only):	

Course Name(s) and/or Textbooks	Course Date(s)	Fee

Payment options are as follows and payment must be submitted with this registration form:

Select One (X)	Description	Amount Due
	Cash, Check or Money Order (Made Payable to HF Training Center)	
	Credit Card (MC, Visa, Discover): # _____ Exp. Date: _____	
	Health First Associates Only-Payroll Deduction : I authorize Health First to deduct over ____One ____Two ____Three pay periods until the amount indicated is paid in full.	

Cost Center Transfer: (not available for CPR or ACLS) Manager Signature: _____ Cost Center #: _____ - _____ - _____	Send form and payment to Barbara Couch: Mailing Address: Health First Training Center 3470 N. Harbor City Blvd. Melbourne, FL 32935 E-mail address: barbara.couch@health-first.org Phone: (321) 434.1972 Fax: (321) 254.0795
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By signing this form, I agree my registration fee will be forfeited if I fail to cancel my registration within 48 hours of the start time of the course. A \$10.00 fee will be charged to process all refunds.

If I elected Payroll deduction, I understand and agree that upon my severance of employment, whether voluntary or involuntary, any balance due for this deduction will be withheld from my final check and/or from pay out of accrued PL. Additionally, if this course is of no cost to me, and I fail to cancel within 48 hours as noted above, a \$10.00 fee will be deducted from my paycheck.

Signature (Required)

Date

Office Use Only:
 Authorized by: _____ Date: _____

GL Account #050 600001 6405 52 - Training Center