

Medical Massage  
REGISTRATION FORM

PERSONAL INFORMATION							
Last:		First:					
Address:		City:		State:		Zip:	
Home Ph.		Work:		Cell:			
Email:							
CREDIT CARD INFORMATION							
Credit Cards (Visa, MasterCard)							
Name:	(exactly as it appears on the card)						
Card #:		Exp Date:					
Card ID:	(3 Digit number located on the back of the card)						
Signature:							
Billing Address (if different than above):							
WORKSHOP OR WORKSHOPS YOU ARE INTERESTED IN ATTENDING AND THE DATE							
***For early registration prices, payment must be received 2 weeks prior to class***							
Workshop:		Date:		Price:			
Workshop:		Date:		Price:			
Workshop:		Date:		Price:			
Workshop:		Date:		Price:			
*Please print and mail the completed form to the address below*							
Make check payable to: Medical Massage for Chronic Pain, LLC 1001 Farmington Ave, Suite 101 Bristol, CT 06010							
<b>SAVE WITH EARLY REGISTRATION!</b>							