

**Registration Form for Trainings**

Company Name:

Company Billing Address:

Attendee First Name:

Attendee Last Name:

Attendee Phone Number:

Attendee Email address:

Name & Date of Training:

Cost: $25.00

Payment Type: *(*Circle one*)* Invoice, or Credit Card

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Type of Credit Card: (Check one)  Personal  Business

Credit Card:  MC  VISA  Other

Card # 3-digit Pin on back

Expiration Date: /

Name on Credit Card:

Card Holder Phone #:

Card Holder Email Address:

Card Holder Mailing Address:

**REMINDER:** If paying by credit card please fax your card information to 920.749.2399 or send via encrypted email to: [atworkeap@ThedaCare.org](mailto:atworkeap@ThedaCare.org) If you have questions call main office 920.749.2390