



## Registration Form

**Return completed Registration Forms along with your payment to:**

**Email:** [register@infusionknowledge.com](mailto:register@infusionknowledge.com) • **Fax:** 727-442-6874

**Mail:** P.O. Box 8649, Clearwater, FL 33758

***Please complete all of the following information:***

Full Name *(to appear on course certificate)*: \_\_\_\_\_

Professional Designation *(i.e. RN, ARNP, etc.)*: \_\_\_\_\_ License # \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Day of Class Phone: \_\_\_\_\_ ***In case of an emergency on the day of class.***

Employer: \_\_\_\_\_ Department: \_\_\_\_\_

How did you hear about this class? \_\_\_\_\_

### ***Method of Payment***

Check or Money Order  Visa  MasterCard  Discover  AmEx

Name *(as it appears on credit card)*: \_\_\_\_\_

Address of Card Holder *(if different than above)*: \_\_\_\_\_

Card # \_\_\_\_\_ Exp.: \_\_\_\_\_ Security Code: \_\_\_\_\_

Authorized Signature *(initial if sending electronically)*: \_\_\_\_\_

### ***What class are you registering for?***

Class Name: \_\_\_\_\_

Date(s): \_\_\_\_\_ Location: \_\_\_\_\_

Amount Enclosed: \$ \_\_\_\_\_ Applicable Discount: \_\_\_\_\_

*\* Please see our website for the discounts that are currently available.*

**You will receive a confirmation/receipt via email within 3 business days of receipt of your Registration Form.**

***Cancellation Policy***

*Infusion Knowledge, Inc.* must receive all cancellations in writing no later than 14 days prior to the class date. Refunds are generally not issued after that date unless mitigating circumstances apply.

We reserve the right to cancel any class if sufficient registrations are not received 1 week prior to any class date.

*Please call Infusion Knowledge, Inc. at 1-800-337-1545 with questions.*