



COURSE REGISTRATION FORM

Please e-mail or fax this registration form & payment to:
Chicago Pediatric Therapy and Wellness Center
Email: rose.mclean@cptwc.com FAX: (773) 305-5543

Name _____ Discipline _____

Address _____

City _____ State _____ Zip _____

Phone # () _____

Fax # () _____

Email address _____

Course Title _____ Cost _____

Credit card please complete and sign the following:

Visa (13 or 16 digits) MasterCard (16 digits) American Express (15 digits)

If using a Visa card, please provide the 3 digit code located on the signature side of the card

Number: _____

Expiration date: _____ (month / year)

Code: _____

X _____ Signature of cardholder

Date _____

Please PRINT the cardholder's name and address zip code as shown on the card

Refunds are given up to 3 weeks prior to the course date, minus a \$50.00 processing fee. A written notice must accompany this cancellation and be postmarked 21 days prior to the course. Confirmation of registrations based on postmarked receipt of payment in full. NO partial payments accepted. CPTWC, LLC. reserves the right to cancel any course with due cause and refund in full.