

## CBRF Medication Administration Class Registration Form

**All information is required. Please print.**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Birth date: \_\_\_\_\_ Last 4 digits of Social Security Number: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

*Please circle dates of class registering for below (all classes are held from 10-5):*

January 9 & 10

February 13 & 14

March 12 & 13

April 9 & 10

May 14 & 15

June 11 & 12

I, \_\_\_\_\_, understand the details of the class as outlined. I also understand that cancellation is required two weeks in advance to receive a refund of the class fee. Cancellations after that time will *not* be refunded the class fee. Reservations are final once payment and registration form is received by Lakeview Pharmacy.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

- I have enclosed payment in the form of two checks. One is made payable to Lakeview Pharmacy in the amount of \$100 and the other is made payable to UW Oshkosh in the amount of \$15.

-----

**Office Use Only**

Recd: \_\_\_\_\_ Recorded: \_\_\_\_\_ Payment Processed: \_\_\_\_\_