



TRAINING REGISTRATION FORM

NAME: _____
(Print clearly for certificate)

OCCUPATION: _____

D.O.B: _____

AGENCY/ORGANIZATION: _____

STREET ADDRESS: _____
(AGENCY/ORGANIZATION OR HOME)

CITY: _____ STATE: _____ ZIP: _____

TELE: _____ FAX: _____

PREFERRED MAILING AND BILLING ADDRESS: _____

EMAIL CONTACT: _____

COURSE TITLE AND DATE: _____

AREA OF EXPERTISE: _____

NUMBER OF STUDENTS ATTENDING: _____

PLEASE PROVIDE MEDICAL BACKGROUND FOR ANY SPECIFIC LIMITATIONS IN TRAINING

PAYMENT TYPE (PLEASE CHECK ONE)

COMPANY/AGENCY CHECK _____ MONEY ORDER _____ ORGANIZATION PO _____

CREDIT CARD PAYMENT: VISA _____ MC _____ AMEX _____ DISC _____

CREDIT CARD NUMBER: _____ Exp: _____ Sec. Code: _____

Mail registration and payment to: **P.O. Box 6936, Piscataway, NJ 08854**

Payable to: **Awareness Protective Consultants, LLC**

If faxing registration and purchase order, please fax to **1-866-635-5761**

*****ANY RETURNED CHECKS WILL INCUR A CHARGE OF \$35.00*****

*****FULL PAYMENT DUE UPON REGISTRATION FORM SUBMITTAL*****

CANCELLATION POLICY:

Student will receive full refund of fee if cancelled in writing 30+ days prior to course start date. All cancellations must be submitted in writing. Cancellations that are received after that will be responsible for full payment. **NO WRITTEN NOTICE - NO REFUND**

