

LEAF REGISTRATION FORM September 22 – November 17, 2016

Lifestyle Education And Food Program (LEAF)

(PLEASE PRINT LEGIBLY)



Name _____ Last _____ First _____ Middle Initial _____

Preferred Name on Name Tag _____

Mailing Address _____

City _____ State/Province _____ Zip/Postal Code _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

FAX: (____) _____ E-Mail _____

Occupation (or former occupation) _____ Employer _____

Date of Birth: Month _____ Day _____ Year _____ Male Female

Primary Physician _____ Phone _____

I heard about LEAF from: (check all that apply) Brochure CHIP/LEAF Alumni

Church Bulletin Dentist Newspaper Physician Poster

Radio Television Other _____

My first and second health concerns are: Cancer___ Cholesterol___ Diabetes___
Heart Disease___ Hypertension___ Weight___ Other_____

Please list any FOOD ALLERGIES: _____

In Case of Emergency notify: Name _____ Phone (____) _____ - _____

LEAF Registration Fee – REGISTRATION DEADLINE – September 12, 2016

Adult _____ \$199.00 \$ _____

Couple (sharing materials) _____ \$373.00 \$ _____

ALUMNI \$119 includes 2 healthscreens (+optional \$10 resource book, \$15 notebook) \$ _____

Other: Scholarship/Pre-Arranged Discount \$ _____ \$ _____

Method of Payment: RECEIPT # _____

Cash _____ Total \$ _____

Check # _____ Payable to *The Maple Center*

LEAF TESTIMONIAL AND PHOTO RELEASE (OPTIONAL)

Please read the release statement and sign below.

The Maple Center, Inc. /Wabash Valley LEAF program has my permission to use my name, testimonials, and photos/video documented during the LEAF program. I understand that this release includes the following possible uses: The Maple Center’s website, newsletter, nonprofit annual report, LEAF promotional materials; grant funding documentation; and/or for publicity (print, TV, Radio).

Signature _____



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