REGISTRATION FORM
CANCER, DIABETES, KICKSTART YOUR HEALTH CLASS
DATE_____

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 this class 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 (____) _____-_____

Registration Fee

☐ Cancer (4 week class)	$70.00	$_____
☐ Diabetes (4 week class)	$70.00	$_____
☐ Kick Start Your Health (5 week class)	$85.00	$_____
☐ Other: Scholarship/Pre-Arranged Discount Percent_____		$_____
TOTAL Amount Due		$_____
Amount Paid		**$_____**

Method of Payment:

☐ **Cash RECEIPT #_____** ☐ **Paypal** ☐ **Check #_____(Payable to *The Maple Center*)**

TESTIMONIAL AND PHOTO RELEASE

Please read the release statement and sign below.

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

Signature _____

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