TRAINING COURSE ENROLLMENT FORM

Training Course Date: _____

Training Course Date: _____

Training Course Date: _____

Attendee 1: _____

Attendee 2: _____

Email 1: _____

Email 2: _____

Facility: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Manager's Name: _____ Email : _____

Phone: _____

*Enrollment fees are non-refundable if cancellation is received 3 weeks (15 business days) or less before course date.
*All payments are due in full 30 days prior to course to guarantee availability.
*Please note: Travel arrangements and accommodation are not provided in cost.

☐ Payment Option 1 (Credit Card)

☐ Visa ☐ Mastercard ☐ AMEX

Card No: _____

EXP Date: _____

Total Enrollment FEE: _____

Signature: _____

Billing Address (If different than above): _____

City: _____ State: _____ Zip: _____

☐ Payment Option 2 (Pay by Check)

☐ Contract/UMP = No Charge

PO#: (optional) _____

Submit Print

Remit Payment to:

Avante Health Solutions

1040-A Derita Road, Concord, NC 28027 1.800.958.9986