

FAXED TO: _____
DATE: _____ INITIALS: _____

AR# _____
CC _____

MIDLAND COLLEGE
HEALTH SCIENCES CONTINUING EDUCATION
COURSE/SEMINAR REGISTRATION FORM

Online VCT

_____-_____-_____
Today's Date

_____	Alzheimer's Disease	\$ 25.00	_____-_____-_____
Course Number	Course Name	Course Fee	Course Starting Date
_____	_____	\$ _____	_____-_____-_____
Course Number	Course Name	Course Fee	Course Starting Date
_____	_____	\$ _____	_____-_____-_____
Course Number	Course Name	Course Fee	Course Starting Date

_____-_____-_____
Social Security Number Date of Birth E-Mail Address

Last Name First Name MI

Street Address City State Zip Code

County of Residence Home/Evening Phone Cell/Pager

Work/Day Phone Employer Name (Optional)

OPTIONAL: The following information is requested by the State of Texas for reporting purposes

Sex: Male Female

Ethnicity: White (1) Black (2) Hispanic (3) Asian (4) American Indian (5) Other (6)
Continuing Education Student GED High School Grad Associate Degree
Baccalaureate/+

Please check any that apply:

Displaced Homemaker (7) Single Parent (8) Economically Disadvantaged (2)
Individual w/Disability (3) Limited English Proficiency (4) Learning Disability
Record Privacy Restriction

Payment Method: \$ _____ Check \$ _____ Cash \$ _____ Charge VISA MasterCard Discover A/R
Account Number _____ Expiration Date _____
Cardholder's Signature _____

Refund Policy: 100% Canceled Course ~ 100% Prior to first class day* ~ 80% Prior to second class day*
* Less a \$10 processing fee. All refund forms must be completed in person. Allow 30 days for processing.