



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** \$ _____

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 and diabetes 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 _____



The Maple Center for Integrative Health
1801 North Sixth Street, Suite 600
Terre Haute, Indiana 47804
Phone (812) 234-8733, Fax 812-232-8059
www.themaplecenter.org

