

INTRAFITT ALLIED HEALTH CARE PROFESSIONAL
Clinical and Sports Nutrition
CERTIFICATION CLINIC
REGISTRATION FORM

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security: _____ E-Mail Address: _____

Home Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Date of Birth: ____/____/____ Drivers License#: _____

In Case of Emergency, Contact: _____

Phone: (____) _____ - _____

Place of Employment: _____

Occupation: _____

I would like to pay my registration fee of (\$399.00) for PART I / PART II or PART I and PART II for (\$749.00) with:

- Visa** **MasterCard** **Money Order/Certified Check***

Credit Card Number: _____ Exp. Date: ____/____/____

*If certified check or money order, is your desired method of payment, please make check payable to **INTRAFITT** and mail along with your registration form to :

INTRAFITT
8417 Calvin Ave. Northridge, CA. 91324
OR

You may fax your registration form and credit card payment to (818) 772-0202

NOTE: Registration fees are non-refundable once they are received.

I _____ certify, that I have read and fully understand and agree to the terms and conditions as described on this form and in the "Registration Information" which has been provided to me via the INTRAFITT website at http://www.intrafitt.com/certifications_workshop.asp

Signed: _____ Date: _____

SEND ALL QUESTIONS AND COMMENTS TO CERTIFY@INTRAFITT.COM