



**Veterinary Technician
Continuing Education Symposium
Registration Form**

_____ Date

_____ Last Name First Middle Initial

_____ Permanent Home Address: Number and Street Apt.

_____ City State Zip Code

_____ Phone number(s) Fax number Email (Please Print)

_____ Hospital/Clinic (Name/Address)

CEU Certificate: _____
(Please indicate how name should read.)

Enclosed is my payment of \$_____. (Half-Day Program: \$35; Full-Day Program: \$85)

Method of Payment: Visa Mastercard Check (Payable to Mount Ida College)

PLEASE PROVIDE THE FOLLOWING INFORMATION IF USING A CREDIT CARD:

Credit Card # _____

Expiration Date _____ CVV (3 digit number located on the back of the credit card) _____

Cardholder's Name _____

Signature _____ Date _____

Please mail check to: Office of Continuing Education, Mount Ida College, 777 Dedham St., Newton, MA 02459 **OR fax form along with credit card information to:** 617-928-4656.

Registration confirmation will be sent to the e-mail address above.