TRIGENICS® SPINE MANIPULATION SEMINAR
REGISTRATION AGREEMENT

Registrant Information (please PRINT clearly)

First name: _____ Last name: _____: Title: _____

DOCTOR / THERAPIST License # _____ Province: _____

STUDENT (Date of Graduation) mo/yr_____/_____

Address: _____

City: _____

State: _____ Zip: _____ E-mail: _____

Phone(s): Work_____ Home: _____ Fax: _____

Special Bonus: Seminar attendees also get 15% discount on any Registered Trigenics Physician Condensed Internship Course (R.T.P.).

Credit Card Holder's Name: _____

(Circle) VISA/MC/AMEX #: _____-_____-_____-_____ Exp. ___/___

I (we) hereby authorize the Trigenics Institute to debit my VISA, MasterCard, or American Express through paper or electronic entry, in the

Total amount of $ _____

I certify that I have read and understand the terms of this agreement and the **Trigenics® Institute** rules and policies and agree to abide by such policies and acknowledge receipt of a copy of this agreement.

Print name: _____ Signature: _____

Date: _____

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