ADVANCED RADIOTHERAPY CONSULTING

Registration for Board Review Course

Please type or print information.

Name: _____ **Title:** _____

Home Address: _____

_____

_____

Work Address: _____

_____

Work Phone: _____

Email Address: _____

Please indicate which Course you are interested in with the applicable date:

Dates	**Course**
_____	Dosimetry Review Course
_____	Therapy Physics Oral Boards Review Course
_____	Medical Physics Written Review Course

Advanced Radiotherapy Consulting
P.O. Box 208
Osceola
IN 46561-0208

Please indicate your method of payment for Deposit or Total Fee:

_____ **Money Order**

_____ **Checks** (Make checks payable to **Advanced Radiotherapy Consulting**)

_____ **Credit Card** (Circle which card)
Visa / Master Card / Discover / American Express

Credit Card Number: _____
Expiration Date: _____
Amount to be Charged: _____
($1,000.00 deposit or total fee $2,100.00)

Signature _____

If paying deposit at this time, what form of payment will balance be?

_____ **Money Order**

_____ **Checks** (Make checks payable to **Advanced Radiotherapy Consulting**)

_____ **Credit Card** (Circle which card)
Visa / Master Card / Discover / American Express

Credit Card Number: _____
Expiration Date: _____
Amount to be Charged: _____
(Amount to be charged for remaining balance)

Signature _____

Final Payment is due within 10 days of course date.

Applicant's Signature _____ **Date** _____

Disclaimer: *ARC does not guarantee that the individual taking the Applicable certification test will pass the exam.*