

*Advanced Radiotherapy Consulting
P.O. Box 208
Osceola, IN 46561-0208
Phone 574-674-6855
Toll Free 866-537-2200
Fax 574-674-6952*

Registration for Radiation Oncology Nurses Training

Name _____

Title _____ Position _____

Years Experience / Oncology? _____ Radiation Oncology? _____

Home Address _____

Home Phone _____

Work Address _____

Work Phone _____

Email Address _____

Please indicate which Course Date you are interested in.

2004 Course Dates

2005 Course Dates

_____ August 14 - 15

_____ February 12 - 13

_____ October 16 - 17

_____ April 2 - 3

_____ December 11 - 12

_____ June 25 - 26

_____ August 13-14

Please indicate your method of payment for deposit or total fee.

_____: Money Order

_____: Checks (Make payable to Advanced Radiotherapy Consulting)

_____: Credit Card (Circle which card)
 Visa / MasterCard / Discover / American Express

Credit card number: _____

Expiration date: _____

Amount to be charged: _____

 (\$100.00 deposit or total fee \$1,200.00)

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

_____: Money Order

_____: Checks (Make payable to Advanced Radiotherapy Consulting)

_____: Credit Card (Circle which card)
 Visa / MasterCard / 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 Signature

Date
