

# **COURSE REGISTRATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (H): \_\_\_\_\_

Phone (W): \_\_\_\_\_

Certification Level: \_\_\_\_\_ EMT \_\_\_\_\_ EMT-P \_\_\_\_\_ PHRN

Squad/Hospital Affiliation: \_\_\_\_\_

Date: \_\_\_\_\_

Course Cost: \$ \_\_\_\_\_

Please Print and mail registration along with payment to:

***BURHOLME FIRST AID CORPS***

**C/O Continuing Education Program**

**830 Bleigh Street**

**Philadelphia, PA 19111-3016**