



**Small Animal ULTRASOUND Basic Level Seminar**  
**Registration Form**

**HOSPITAL NAME:** \_\_\_\_\_

**ATTENDEE'S NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

(As it will appear on your certificate. Please PRINT)

**CITY:** \_\_\_\_\_ **STATE/Zip:** \_\_\_\_\_

**PHONE NUMBER (AM):** \_\_\_\_\_

**PHONE NUMBER (PM):** \_\_\_\_\_

**FAX NUMBER:** \_\_\_\_\_

**E-MAIL ADDRESS:** \_\_\_\_\_

**LICENSE NUMBER:** \_\_\_\_\_

**FOOD PREFERENCE: VEGETARIAN? YES / NO**

Please mail or fax registration with payment to:

Choice Medical Systems, Inc.  
1426 Pasadena Avenue South  
St. Petersburg, FL 33707

Phone: 800-368-9337, 727-347-8833, Fax: 727-347-7140, carmen@choicemedical.com

**CC#:** \_\_\_\_\_

MC / Visa / AX

\_\_\_\_\_ **Sec. Code** (MC/Visa/Discovery: last 3 digits on the back. AX: last 4 on the front)

**Signature:** \_\_\_\_\_

**Credit Card Name** (if different than above): \_\_\_\_\_

**Billing address** (if different than above): \_\_\_\_\_

**Registration Fee: \$950.00**

If canceling within 2 weeks before class, a \$100 fee will be charged for your cancellation. If canceling within 1 week before class, then no monies will be refunded. If the seminar is cancelled, 100% of monies paid will be refunded. Registration is LIMITED and will be filled on a first come, first serve basis by receipt of payment.

I would like to receive information about future courses @ the following email address: