Crystal Rain Training Center
Phlebotomy Continuing Education Workshop
Registration Form

Full Name: _____ Date: _____

Occupation: ☐ RN ☐ LPN ☐ PCT ☐ EMT ☐ MA ☐ Other Medical Field _____

Must submit a copy of your license or certificate as proof of your occupation to the session.

Preferred Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone ( ) _____ **Cell Phone** ( ) _____

Email:_____

Workshop Fee:{ $550.00} (Non-refundable) Final payment must be paid on or before the first session.
A deposit of {$275.00} (Non-refundable) deposit is due at the time of registration to secure your spot.

Workshop Hours: TBA Workshop Days: TBA

Please check your method of payment below ⇩

PAYMENT METHOD: ☐ Money Order ☐ Cashier Check ☐ Cash Credit/Debit Card

(Please read the statement below)

☐ **I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that any false document may disqualify me from attending the workshop including (no-refund) and/or (non-transferable) However, if I have already registered and paid registration fee and are unable to attend the workshop my registration fee may be transferred to the following workshop. I will only have (4) attempts to transfer after the (4th) attempt my registration fee will be forfeited and will cause me to pay a new registration fee.**

Contact Person:
Professor Danette Vercher (910) 286-9436 Email: crystaltrainingcenterllc@gmail.com

Print : _____

Signature : _____

For Admin Use Only

Workshop Class Date:_____
Amount Paid: _____
Have Medical Background Documents Been Attached: _____ Yes _____ No
Copy of I.D: _____ Yes _____ No