

Dance Medicine Practicum Registration Form 2010

(Please print form and fax to 212-541-8582 or mail to: 53 Columbus Avenue, New York, NY 10023)

Name: (please print) _____

Email: _____

Home Address: _____

City/State/Zip: _____

Country(if not U.S.): _____

Phone: Work: _____ Cell: _____

Fax: _____

Occupation: _____

License (if applicable)/ Required to participate in joint mobilization/Grade V techniques:
Type (PT, MD, DPM, DO etc): _____

License #/State: _____

Employer: _____

Employer Address: _____

Registering for: (please check the Module(s) you are registering for)

Module III Sept 24-26 _____

Module IV Oct 1-3 _____

Enclosed is a check for: (\$575 for each module) _____

Please make out check to : Westside Dance Physical Therapy

Please bill my credit card for the fee:

Credit card number: _____ Expiration: ____/____