AIM Training
Registration Form

Program Training

☐ Applied Integrative Medicine: **A Hands-On Training for Healthcare Practitioners**

Name:____

Address: ____

____

Cell Phone:_________________ **Work Phone:**________________ **Other Phone:**________________

Email:____

☐ **Early Bird: $3900 (Date applied: ______)** **Department/Organization**_________________________

☐ **UMMS: $4200** **Department/Organization**_________________________

☐ **Non-UMMS: $4500** **Department/Organization**_________________________

Department/Organization assistance (*if applicable*)__Y__or__N__

Method of payment

☐ Credit Card

☐ Check (*Please make checks payable to **UMB Foundation, Inc.***)

Send check to: **ATTN: Christine Barnabic, Center for Integrative Medicine**
520 West Lombard Street, East Hall
Baltimore, MD 21201

CC Type (*circle*): Visa Master Card Discover American Express

Payment Amount: ________

Card Number _______-_______-_______-_______ **Exp. Date**_____/______ **Security #**____________

Name as it appears on the credit card____

Signature____

Billing address (*if different than above*) ____