

-----  
**CLASS REGISTRATION (Please print legibly)**

Name of Course: \_\_\_\_\_ Date scheduled: \_\_\_\_\_

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

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

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Fee enclosed: \_\_\_\_\_ Check \_\_\_\_\_ Cash \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Best phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Receipt of payment ensures registration. There will be no confirmation or notification unless there is a change or cancellation. 24-hr. notice of withdrawal is required for refunds. Thank you for your interest in your local American Red Cross Health & Safety Program.**

Receipt # \_\_\_\_\_ Check # \_\_\_\_\_ Received by \_\_\_\_\_ Fin. Assoc. \_\_\_\_\_