

**AUTOMOTIVE INSTALLATION TRAINING CLINIC
REGISTRATION FORM**

Class Date: **April 23rd, 2005**

Company Name: _____

Address: _____

City: _____ Prov. _____ Postal Code: _____

Telephone: _____

Number of participants: _____
(\$175.00 first person, \$100.00 for each additional person) + GST + PST.
Total \$ _____ (non-refundable)

Cheque enclosed:

Charge to VISA / MasterCard Acct.# _____

Expiry: _____

Name(s) of participants(s):

Date: _____, 2005

Signature: _____

FEE IS FOR SPECIFIC CLINIC DATE. NO REFUNDS ALLOWED.