



TRAINING REGISTRATION FORM

NAME: _____
(Print clearly for certificate)

OCCUPATION: _____

D.O.B: _____

AGENCY/ORGANIZATION: _____

STREET ADDRESS: _____
(AGENCY/ORGANIZATION OR HOME)

CITY: _____ STATE: _____ ZIP: _____

TELE: _____ FAX: _____

PREFERRED MAILING AND BILLING ADDRESS: _____

EMAIL CONTACT: _____

COURSE TITLE AND DATE: _____

AREA OF EXPERTISE: _____

NUMBER OF STUDENTS ATTENDING: _____

PLEASE PROVIDE MEDICAL BACKGROUND FOR ANY SPECIFIC LIMITATIONS IN TRAINING

PAYMENT TYPE (PLEASE CHECK ONE):

COMPANY/AGENCY CHECK _____ MONEY ORDER _____ ORGANIZATION PO _____

CREDIT CARD PAYMENT: VISA _____ MC _____ AMEX _____ DISC _____

CREDIT CARD NUMBER: _____ Exp: _____ Sec. Code: _____

(SECURE LINKPOINT LINE)

Mail registration and payment to: P.O. Box 6936, Piscataway, NJ 08855

Payable to: Awareness Protective Consultants, LLC

If faxing registration and purchase order, please fax to 1-866-635-5761

ANY RETURNED CHECKS WILL INCUR A CHARGE OF \$35.00

FULL PAYMENT DUE UPON REGISTRATION FORM SUBMITTAL

CANCELLATION POLICY:

Student will receive full refund of fee if cancelled in writing 30+ days prior to course start date. All cancellations must be submitted in writing. Team APC will charge a \$100.00 cancellation fee if written notice is received less than 30 days prior to start date. **NO WRITTEN NOTICE - NO REFUND**