Functional Action, Inc.

Locomotion Enhancement Specialists

Course Registration/Credit Card Payment

Name_____Clinic _____

Address_____City_____State/Province_____

Country_____ E-mail_____

Phone _____ Fax_____

Please describe the course (Level, Location, Dates) for which you are registering:

Course Description_____

_____

Location_____ Dates_____

PAYMENT METHOD

CREDIT CARD TYPE _____A/E _____M/C _____VISA

CARD #_____EXPIRATION _____/_____AMOUNT_____

Code on back side of your card: (3 digits for Visa/MC; 4 digits for AE)_____

Postal/Zip Code where your credit card charges are mailed_____

Please note: Credit card charges will be charged to F.I.R.S.T. Health.

_____ _____

Authorizing Signature Printed Authorizing Name

Notes:_____

****Please Fax Completed Form to +1-310-793-0200****