

CHFS TRAINING ENROLLMENT APPLICATION - 2008

Personal Information (please print clearly and neatly)

Name _____
First Last Middle

Gender _____ Date of Birth ____/____/____ Occupation _____

Street Address _____ Unit/Apt. _____

City _____ State _____ Zip Code _____ Country _____

Is the above address also your billing address? yes no (If no, please complete the next section)

Billing Name _____
First Last Middle

Billing Street Address _____ Unit/Apt. _____

City _____ State _____ Zip Code _____ Country _____

Please give a brief history of your educational background: _____

Contact / Payment Information

Phone Numbers: _____
Home Cell Work

Primary E-mail Address: _____

Credit Card type (Visa/MC, Disc or Amex): _____ Card Holder Name: _____

Credit Card #: _____ Exp. Date: _____ *Card ID #: _____

*Card ID # prevents fraud. Visa, MC & Discover - 3 digits on back of card. Amex - 4 digits on front of card.

How did you hear about us? _____

Which CHFS training would you like to attend? _____

Were you referred to the CHFS Training by one of our affiliates or graduates? List their name(s) here:

First Last

Please fax this completed form to (480) 393-5410 or mail to:

Immunitrition, LLC
P.O. Box 430
Franklin Square, NY 11010-0430