REGISTRATION FORM

Please send in this form with your payment to: **Pleins Pouvoirs KIDPOWER Montreal**

POSTAL MAIL: **P.O. Box 50016, station Jarry, Mtl (QC) H2P 0A1** E-MAIL: **montreal@kidpower.org** FAX **514-990-7124**

We limit workshop size in our groups. **Your deposit is needed to guarantee you a spot.**

Name of Participant/Parent: ______________________

❍ Female ❍ Male

Birth Date: ______________________

Name of children (if applicable)

______________ Birth Date : ______________

______________ Birth Date: ______________

Special Needs: ______________________

Address: ______________________

City: ______________________

Postal Code: ______________________

Email: ______________________

Tel. home:______________________

Tel. work: ______________________

Cell: ______________________

Other : ______________________

Workshop Name: ______________________

Workshop Date(s): ______________________

My deposit is of ____________ $

I pay by: ❑ Check ❑ Cash

❑ Money Order ❑ Gift Certificate

❑ Visa ❑ MasterCard

If by credit card, the number is:

________ - ________ - ________ - ________

Expiration Date: ________ / ________

Signature ______________________

Paid by: ❑ IVAC ❑ CSST ❑ Employer

If by IVAC/CSST: File # : ______________________

Date of Event: ______________________

Agent: ______________________ Tel. __________

Therapist: ______________________ Tel. __________

RESERVED FOR ADMINISTRATIVE PURPOSES – DO NOT WRITE

MAJ hiver 2009

Registration management	**Handled by**	**IVAC / CSST Management**	**Handled by**
Received on:		Request:	
Deposit handled on:		Authorization:	
Confirmation @: Confirmation 🖂:			