



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

Notes: _____

****Please Fax Completed Form to +1-310-530-4464****