

REGISTRATION FORM

Please send in this form with your payment to:

Pleins Pouvoirs KIDPOWER Montréal, P.O. Box 48561, station Van Horne, Montreal (QC) H2V 4T3.

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

Credit Card Numbe :

_____ - _____ - _____ - _____

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 ☒:			