

PCEO Registration Form

FEES

\$ 15 Member
\$ 50 Non -member

Please copy registration form if necessary.

One person, one program, one check per registration form. Thank you.

Program Title _____

Program Date: _____

Name _____ Title (RN, SW, etc.) _____

Home Address _____

City/State/Zip _____

Daytime Phone _____

For email confirmation-- email Alicia @ LinkA@childrensdayton.org

Employer: _____

Manager *: _____

****Manager signature required for AWHONN courses and NRP Instructor course***

Please indicate special needs _____

Course fee amount enclosed \$ _____ **

****See course description for appropriate fee information**

Retired employee -- Member institution _____

Make check/money order payable to: The Children's Medical Center - PCEO

Mail to: Newborn Medicine Office/ PCEO Program

One Children's Plaza

Dayton, Ohio 45404-1815

*See class details for registration deadline.
Your are confirmed for offering unless
otherwise notified*

FOR OFFICE USE ONLY

Received _____

Check # _____ Amount _____

12/09