WHOLE HEALTH CLINICAL GROUP
a service of the Milwaukee Center for Independence

CBRF Registration Form

PLEASE PRINT CLEARLY:

Last Name_____ First Name_____ M.I._____

Street Address_____

City_____ State_____ ZIP Code_____

Email Address_____ Phone (_____) _____

Date of Birth(MM/DD/YYYY)_____ Emergency Contact _____

Phone (____) _____ Relationship_____

EMPLOYER INFORMATION (Following information needed ONLY if employer is paying for classes):

Employer Name: _____

Employer Street Address: _____

City_____ State_____ ZIP Code_____

Name of Supervisor: _____ Title: _____

Supervisor Phone: _____ Supervisor Email: _____

CLASSES REGISTRATION AND DATE PREFERENCE: Class schedules are available at: www.mcfi.net
(Please indicate 1st and 2nd class date preferences; refer to monthly schedule for available class dates.)

- ☐ Standard Precautions: $60 Class date: 1st: _____ 2nd: _____
- ☐ Medication Administration: $160 Class date: 1st: _____ 2nd: _____
  (Daytime class – 2 days, Evening class – 4 days)
- ☐ Fire Safety: $75 Class date: 1st: _____ 2nd: _____
- ☐ First Aid/Choking: $120 Class date: 1st: _____ 2nd: _____
- ☐ Same day registration late fee (please call ahead for class availability): $15

PLEASE READ: Students will be enrolled in classes on a first-come basis. If a class is full, students will be enrolled in their second choice. ***All students will receive a letter either via mail or email confirming registration in the class(es).*** *Students will not be registered for classes until payment is received (see payment on the next page). Cancelation or rescheduling of any classes must be done within 48 hours of the registered class. Refunds will not be given if less than 48 hour notice is given. Any refunds may take 4-6 weeks. WHCG reserves the right to cancel/reschedule any classes. Students will be given the opportunity to reschedule. Same day registration is not guaranteed.*

How would you like to receive your registration letter *(Circle one):*

Mail Email

PAYMENT (required) - Please indicate method of payment for the CBRF classes:

- ☐ **Check or Money order** *(Payment made to Whole Health Clinical Group and sent with form)*
- ☐ **Credit card or Debit card** *(complete information below)*
- ☐ **Cash** (exact amount)
- ☐ **Other** (voucher)

Total amount being sent in with this application: $ _____._____ (This amount should cover total payment for all classes you wish to be registered for as indicated on the front of the form. Students will not be registered for class(es) without payment nor can a spot in any class be held pending receipt of payment.)

I, _____, certify that I have fully read this registration form and agree to the terms regarding
(Print Name)
registration in WHCG's CBRF training program. I understand that a registration letter will be sent with additional information regarding my registration in the classes and the dates.

Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____
(Only needed if Employer is paying for classes)

Please complete and return this form (Attention: CBRF Training) via the following:

- Mail: Whole Health Clinical Group, 932 S. 60th St. West Allis, WI 53214
- Email: CBRFTraining@mcfi.net
- In person – Lock drop box available within WHCG's staff/visitor entrance at rear of building

Questions regarding registration or class schedule contact the CBRF Training Office at (414) 459-3026.

Credit Card Information:

Name on Card: _____

☐ Visa ☐ Master Card

Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiration date: ☐☐ / ☐☐

Card Security Code (3 digits on the back): ☐☐☐

Billing Zip Code: ☐☐☐☐☐

By signing, you are authorizing WHCG to charge the above listed card for the total amount of _____ as indicated on this registration form. (Payments will be processed within a few days of receipt of this form.)
(Write Amount)

Signature: _____ Date: _____