



**REGISTRATION FORM
TINNITUS MANAGEMENT WORKSHOP
CALGARY, AB**

FIRST NAME:

LAST NAME:

ADDRESS:

CITY/PROVINCE:

POSTAL CODE:

EMAIL ADDRESS:

TELEPHONE:

PLEASE CIRCLE THE MONTH THAT YOU WILL COMMIT TO OR INDICATE THE MONTH MOST SUITABLE:

APRIL JUNE SEPTEMBER OTHER: _____

PLEASE SELECT METHOD OF PAYMENT FOR \$395.00 * Add \$50 if you wish a significant other to join you.

VISA NUMBER:

EXPIRY:

OR: CHEQUE PAYABLE TO: SOULSPRINGCOUNSELLING INC.