BROOKS Rehabilitation
INSTITUTE OF HIGHER LEARNING

Course Title: _____

Course Registration Form

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email Address: _____

License Number: _____ Clinical Designation (PT, OT, etc) _____

Are you a Brooks employee? ☐ Yes ☐ No

How would you like the course manual?

☐ Hard Copy, Available at the course
☐ Electronic Copy, Emailed 48 hours before the course

*Disclaimer: Participants who choose to receive an electronic course manual will NOT receive a printed manual the day of the course. The electronic course manual will be emailed as an Adobe PDF attachment 48 hours prior to the course date.

How did you hear about this course?

☐ Search Engine ☐ Email Advertisement ☐ Brochure Mailing ☐ Conference ☐ Other _____

Date of Course: _____

Cost of Course: _____

Method of Payment:

☐ Check ☐ Cash ☐ Department*

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*For Brooks employees only. If you are a Brooks employee, and your department is paying for you to attend this course, please provide the cost center number and have your department manager sign below.

Cost Center: _____

Approving Manager: _____ **Manager Signature:** _____
(please print)

Please mail this form along with payment to:
Brooks Rehabilitation
Attn: McKenzie Kelly
3599 University Blvd., South
Jacksonville, FL 32216