
Registration Form

Name _____

Address _____

City _____

State _____

Zip _____

Home Phone _____

Cell Phone _____

Work Phone _____

E-mail address _____

Name of Class or Event _____

Payment: \$10 per person _____

Check # _____

Cash _____

Make your \$10 check payable to St. Cloud Hospital.

How did you hear about the class or event?

(Check all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Doctor's Office: Flier, doctor |
| <input type="checkbox"/> Ad | <input type="checkbox"/> Family/Friend |
| <input type="checkbox"/> Article | <input type="checkbox"/> Work: publications, email, posters, payroll staffer |
| <input type="checkbox"/> Web site | <input type="checkbox"/> Events: class/support group/health fair/conference |
| <input type="checkbox"/> Mail | <input type="checkbox"/> Poster |
| <input type="checkbox"/> Spotlight on Health | <input type="checkbox"/> Internet/Web |
| (St. Cloud Hospital newsletter) | <input type="checkbox"/> St. Cloud Hospital |
| <input type="checkbox"/> Women & Family Health Education Calendar | <input type="checkbox"/> St. Cloud Times |
| <input type="checkbox"/> Postcard | <input type="checkbox"/> Email |
| <input type="checkbox"/> Letter from doctor's office | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Radio | _____ |
| <input type="checkbox"/> TV | _____ |

Please fill out all of the above information and mail with payment to:

Women & Children's Center Outreach Education
1900 CentraCare Circle, Ste 2375
St. Cloud, MN 56303

You are registered for this class or event when we receive this registration form and payment. Be sure to mark your calendar! Please call 320-229-5139 if you have any questions.