



Wilderness Medical Consultants Registration Form

Please Print Clearly

Please print and complete this form and make cheques payable to Wilderness Medical Consultants.

Student Information:

Name: _____ Date of Birth: _____

Gender: _____ Medical Conditions: _____

Mailing Address: _____

Email Address: _____

Phone: _____ Alternate Phone: _____

Course Information:

Course Location: _____

Course Name: _____

Course Dates (start): ____ / ____ / ____ Course Dates (end) ____ / ____ / ____

Payment Information:

If you are mailing or faxing this form to WMC then you have chosen to make your payment by cheque or money order. All credit card payments must be done online through our website. Our prices listed on our website do not include GST so please include this with your payment. Full payment is due when you register for a course.

Course Price (as listed on our website) \$ _____

GST \$ _____

Total Enclosed \$ _____

By signing below I agree that I understand the refund policy of Wilderness Medical Consultants.

Signature Required: _____ **Date:** _____

WMC will contact you to confirm that your registration was received.