

# Health Education Program Registration Form

**(PLEASE PRINT)**

By completing this registration form, you agree to our policies listed on page 7.

## Class selection:

Program title: \_\_\_\_\_ **Fee:** \_\_\_\_\_

Date/Time FIRST choice: \_\_\_\_\_ Level: \_\_\_\_\_

Date/Time SECOND choice: \_\_\_\_\_ Level: \_\_\_\_\_

## Student Information:

1. Name: \_\_\_\_\_ Kaiser Permanente medical record no.: \_\_\_\_\_

2. Name: \_\_\_\_\_ Kaiser Permanente medical record no.: \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State/ZIP: \_\_\_\_\_

Day phone: ( ) \_\_\_\_\_ Evening phone: ( ) \_\_\_\_\_

For nonmembers only: Social Security number: \_\_\_\_\_ Birth date: \_\_\_\_\_

## Payment method:

CHECK (payable to Kaiser Permanente)

AMERICAN EXPRESS /MC /VISA /DISCOVER Cardholder's name: \_\_\_\_\_

Card no.: \_\_\_\_\_ Exp. date: \_\_\_\_\_

If you have any questions, please call Health Education at **(415) 833-3450**

Monday–Friday, 9 a.m.–5 p.m.

**Return form to: Kaiser Permanente, Health Education, Attn: Class  
2241 Geary Blvd., San Francisco, CA 94115**

<b>STAFF USE ONLY</b> Date received: _____ Date processed: _____
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