

# Registration Form

Workshop title \_\_\_\_\_

Date to be held \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Telephone: home (    ) \_\_\_\_\_ cell (    ) \_\_\_\_\_

E-mail \_\_\_\_\_

Occupation \_\_\_\_\_

## Method of Payment:

Enclosed is \_\_\_ check/money order (payable to American Institute of Indian Head Massage)

Bill my credit card:    Visa \_\_\_\_\_    Mastercard \_\_\_\_\_    American Express \_\_\_\_\_

Name on card \_\_\_\_\_

Card No. \_\_\_\_\_ Expiry Date \_\_\_\_\_

Signature \_\_\_\_\_

## Mail to:

**American Institute of Indian Head Massage**

**PO Box 963**

**Williamstown, NJ, 08094**