Freedom From Smoking Facilitator Registration Form

Fax, Mail to the attention Tami Cappelletti, or attach to email
American Lung Association
PO BOX 9067
Louisville KY 40209
Fax: (502) 363-0222
tami.cappelletti@lung.org

Name _____ Credentials _____
Organization _____ Title _____
Mailing Address
_____

City _____ State _____ Zip Code _____

Daytime Phone _____ Business Fax _____

Email _____

A separate form must be used for each person and session. Trainings will take place as scheduled only if a minimum of 6 people per session are registered. Please contact Tami (502)363-2652 with any questions. **TRAINING DATE : February 21 , 2017**
tami.cappelletti@lung.org **Oldham Co. Health Dept Lagrange , KY**

Payment:

$100 registration fee

❒ Check or Money Order Enclosed $ _____

(Make checks payable to ALA)

Signature _____

❒ I am able to provide worksite programs, but as representative of my agency only.

❒ I am not able to provide programs outside my worksite.

❒ Charge to Credit Card $ _____

❒ Visa ❒ MasterCard
❒ Discover
_____ **invoice my work place**
Acct # _____
Exp. Date _____
CVV2 Code _____

❒ I am able to provide worksite programs as a representative for the American Lung Association

I am available to provide clinics on:
(circle all that apply)
M T W Th F Sat
Time of Day:
Daytime Lunchtime Evening