Washburn Center Training Institute
Training Registration Form

Training Information

Training Name: _____

Training Date (Day 1, if multi-day training)**:** _____

Registration Date: _____

Registration Fee: _____

Discount Code (if applicable)**:** _____

Participant Information

First Name:	**Last Name:**	
Organization:	**Clinical Licensure** (if applicable)**:**	
Email address:		
Mailing address:		
City:	**State:**	**Zip:**

Dietary Restrictions (in-person trainings only)			
Vegetarian ☐	**Vegan** ☐	**Dairy-free** ☐	**Gluten-free** ☐
Other ☐ **Please specify:**			

Return completed form to the email address below.

If paying via check, mail check and completed form to the address below. Please email the address below to inform us that your registration is on the way. Registration is secured once payment is collected and you've received a confirmation notice.

United Health Foundation Training Institute at Washburn Center for Children

1100 Glenwood Ave, Minneapolis, MN 55405

traininginstitute@washburn.org

Fax: 612-871-1505, Attn: Training Institute

www.washburntraininginstitute.org