College of Allied Health and Nursing
Continuing Education Registration Form

THIS FORM MAY BE REPRODUCED

- All information is required to complete registration.
- Only ONE person per registration form.

Name_____
Home Address_____
City, State, Zip_____
Telephone (h)_____ (w)_____
Social Security Number_____
Place of employment_____
Occupation/Discipline (for CE credit)_____

Course(s) registration name(s):

Course Name	Date	Location	Fee
REGISTRATION FEE TOTAL			

Make check payable to: **Minnesota State University, Mankato** or
Please charge to my: _____VISA _____Mastercard _____Discover

Card Number:_____Exp. Date_____

Cardholder's Name (print) _____

Signature_____

Mail to:
Continuing Nursing Education
Minnesota State University, Mankato
360 Wissink Hall
Mankato, MN 56001

Questions?: 507-389-6826