



***Craniocervical and Craniomandibular Pathophysiology
Approach to Treatment***

Given by Professor Dr. Mariano Rocabado

**REGISTRATION FORM
September 24 & 25, 2010**

Name: _____

Address for Receipt: _____

Phone number: **(res)** _____ **(office)** _____

Email: **mandatory:** _____

Payment method – Post dated cheque \$507.94, payable to **9212-5061 Québec Inc.**
dated **August 20th 2010** (includes taxes, breaks and lunches).

Cancellation policy: Before August 20th 2010 - Full reimbursement

Between August 21st and September 3rd 2010 - 50 % refund

After September 3rd 2010 - no refund

If you have any specific questions or require more in-depth information please contact us at physiomk@bellnet.ca. Confirmation will be sent via e-mail so please provide this information on your registration form. Please let us know should your email address change after registration.

I _____ have read and understand the registration and
cancellation policy regarding this instructional session.

Signature _____