



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

Given by Professor Dr. Mariano Rocabado

REGISTRATION FORM

March 23 & 24, 2012

Name: _____

Address for Receipt: _____

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

Email: **mandatory:** _____

Payment method – Post dated cheque \$517.39, payable to **9212-5061 Québec Inc.**
dated **February 24th 2012** (includes taxes, breaks and lunches).

Cancellation policy: Before February 24th 2012 - Full reimbursement

Between February 25th & March 9th 2012 - 50 % refund

After March 10th 2012 - 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 _____