



REGISTRATION FORM

Name	Date	Class Attending	Class Date

Class Cost _____

A check will need to be submitted to Tri-State Memorial Hospital & Medical Campus. Please include the cost center 4250-8720000 written on the check. All classes must be paid for with the completed registration form.

Address _____ City _____ State _____ Zip _____

Phone # _____ Email _____

License (RN, LPN, RT, EMS, etc.) _____

Directors Signature _____

(Please have your director sign if this class is not mandatory, but recommended for your job description)

Registration must be completed four weeks in advance for TNCC, three weeks in advance for all other classes.

Please complete this form and send to:

Tri-State Memorial Hospital
ATTN: Clinical Nurse Educator
1221 Highland Avenue
Clarkston, WA 99403

Questions? Please contact the Clinical Nurse Educator at 509.758.5511 ext. 2520 or email jmatoske@tsmh.org

OFFICE USE ONLY

Track Payment:

Book Pickup: