

**The OSU Center for Integrative Medicine  
Class Registration Form**

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Name of Class:** \_\_\_\_\_ **Date of class:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
\_\_\_\_\_

**E-mail Address:** \_\_\_\_\_ **Phone Numbers:** \_\_\_\_\_  
\_\_\_\_\_

**Would you like to be on our e-mailing list for upcoming classes and events?** Y / N

**Are you aware of any medical conditions that may affect your ability to participate in this class?** \_\_\_\_\_

**Other classes you would like to see offered at CIM:** \_\_\_\_\_  
\_\_\_\_\_

**THE OSU CENTER FOR INTEGRATIVE MEDICINE (CIM) EDUCATION CLASSES CAN BE AN INTEGRAL PART OF COMPREHENSIVE MEDICAL CARE, BUT ARE NOT A SUBSTITUTE FOR PRIMARY CARE. THE CIM STAFF WILL DO EVERYTHING POSSIBLE TO ENSURE YOUR SAFETY AND ARE NOT LIABLE FOR ANY INJURY THAT MAY RESULT FROM YOUR PARTICIPATION IN CLASSES. YOUR SIGNATURE IS VERIFICATION THAT YOU HAVE READ AND UNDERSTAND THIS STATEMENT.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Office Use Only:**

**Class Instructor:** \_\_\_\_\_

**Registration Fee:** \_\_\_\_\_ **Paid? Y/ N**

**Method of Payment:**            **Cash**            **Check**            **Debit**            **Credit**

**Visa/Mastercard: Acct#, Expiration Date:** \_\_\_\_\_

**Name on Card:** \_\_\_\_\_

**How to Register:** After completing your registration form, please mail or fax with check or credit card information to the CIM attn: Katie Scholl at 2000 Kenny Rd Cols, OH 43221; fax #293-9776. You can also complete registration at the Center. Space is limited and registration is not completed until payment is received.