Health Education Program Registration Form

(PLEASE PRINT)

By completing this registration form, you agree to our policies listed on page 7.

Class selection:

Program title: _____ **Fee:** _____

Date/Time FIRST choice: _____ Level: _____

Date/Time SECOND choice: _____ Level: _____

Student Information:

1. Name: _____ Kaiser Permanente medical record no.: _____

2. Name: _____ Kaiser Permanente medical record no.: _____

Address _____

City: _____ State/ZIP: _____

Day phone: (____) _____ Evening phone: (____) _____

☐ *For nonmembers only:* Social Security number: _____ Birth date: _____

Payment method:

☐ CHECK (payable to Kaiser Permanente)

☐ AMERICAN EXPRESS / MC / VISA / DISCOVER Cardholder's name: _____

Card no.: _____ Exp. date: _____

If you have any questions, please call Health Education at **(415) 833-3450**
Monday–Friday, 9 a.m.–5 p.m.

Return form to: Kaiser Permanente, Health Education, Attn: Class
2241 Geary Blvd., San Francisco, CA 94115

STAFF USE ONLY
Date received: _____
Date processed: _____

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