

PLEASE PRINT

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Home phone: _____ Cell phone: _____

E-mail: _____

Birth date: _____

Course #	Course Title	Start date	Day/time	Fee
			Processing fee	\$5.00
			TOTAL	

Check Visa MasterCard Am Express

FAX your Credit Card Registration to: 203-255-8243

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EXP. DATE _____

<p>Make check payable to: Fairfield Continuing Education 501 Kings Highway East PO Box 320189 Fairfield, CT 06825</p>
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