



## Registration Form

Please make check payable to **TCHP Education Consortium** and return with registration form to:

Hennepin County Medical Center, TCHP Office  
701 Park Avenue—Mailcode SL  
Minneapolis, MN 55415

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Organization: \_\_\_\_\_ Job title/Dept.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Class/Program(s)title(s): \_\_\_\_\_

Date(s) offered: \_\_\_\_\_