Restorative Aide Training





Please Ch	neck One:			
☐ March 29-31, 2017	September 6-8, 2017			
8:30 a.m 4:30 p.m., AHCA Training Room, Suite 175				
Members \$600, Non-Membe	ers \$3,000 - Lunch Included			

To register, send this completed form to:

Mail: 1401 W. Capitol Ave., Suite 180, Little Rock, AR 72201 / Fax: 501-374-1077 / Email: Ikindy@arhealthcare.com
The information contained herein, together with all attached documents, will be regarded as property of AHCA.

First Name	M.	Last Name		Last 4 digits of SSN
Home Address		City	State	Zip
Cell Phone		Email Address (to receive	confirmation, class info	ormation, and notifications)
Employer		Current Title		
Employer's Address		City	State	Zip
C.N.A. Certificate Number		Date Received		
Attendee's Signature				Date
PAYMENT TOTAL: \$				
Check #:	_ Visa Master Card	American Express		
Name on Card:		Credit Card Number:		
Expiration Date:		V-Code:		
Billing Address:				
City:		State:	7in:	

SPACE IS LIMITED. ADVANCED REGISTRATION IS REQUIRED.
PAYMENT DUE BY FIRST DAY OF CLASS.
CONFIRMATION WILL BE SENT.

For more information, please contact Lori Kindy, Director of Education, 501-374-4422, lkindy@arhealthcare.com