Registration Form



NAME OF PROGRAM	DATES OF PROGRAM	COURSE/WORKSHOP#
Dr./Mr./Ms . First Name MI Last Name	Degree(s)	
Job Title Departm	ent	
Therapeutic Area of Work		
Company		
Address		
City State Co	untry Zip/	Postal Code
Email	Talanhana	Fox
Email	Telephone	Fax
How did you hear about us? ☐ Catalog ☐ Linked In ☐ Email ☐ Colleague ☐ Website ☐ Conference		
PERI's Certificate Programs (Visit our website for more information) Please sign me up in the following professional areas:		
Basic Research Clinical Sciences	Project Managem	ent Quality Assurance Compliance
Participant Profile This section must be completed for your registration to be processed. It is strictly confidential and it is used by the faculty to help fine tune their presentations to fit the needs of the audience. Attach an additional sheet if necessary. 1. How long have you been in your current position? 2. Identify below three specific learning objectives you want to accomplish: 3. How will you apply the information gained from this course to your job?		
Payment Method PERIT.	AX ID #54-1761961	How may we contact you in order to provide information on future PERI Courses? Please check
Check enclosed. Please make checks in U.S. dollars payable to P We regret we cannot accept personal checks.	PERI, Inc.	all that apply. MAILEMAIL
Check Request Enclosed. (Note: PERI requires payment at least t start of the program.)	hree weeks prior to the	WAILLWAIL
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Card Number		PERI, Inc.
Exp. Date CSC Number on Card		4000 Legato Road
Name of Cardholder AS IT APPEARS ON CARD		Suite 1100
Address of Cardholder		Fairfax, VA 22033 USA Phone: +1-571-490-8409
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\$Total Amount Charged or Enclosed		You can also register for courses on our website at www.peri.org.