

REGISTRATION FORM

Name (print) _____

Title _____

Department _____

Zip + 4 _____ Phone _____

Bargaining Unit: UUP CSEA NYSCOPBA PEF Council 82 OR

Research Foundation MC FSA

Supervisor's Name (print): _____

Supervisor's Signature _____

Please list your choices below:

	Workshop Name	Date(s)	Time
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Workshop confirmations will be mailed directly to you approximately two weeks prior to start date of each workshop.

SEND FAXES TO: (631) 632-2414