

Mail- In Course Registration

Course Title: _____

Course Date: _____

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Daytime Telephone: _____ **Email:** _____

License Type: _____ **State:** _____ **Number:** _____

Amount Enclosed: _____

Make and mail checks out to:

CCWF

P.O. Box 3294

Los Altos, CA 94024

