COLLEGE OF
MOUNT SAINT VINCENT

Health Care
Medical Assistant Administration Program

REGISTRATION FORM

Personal Information:

Last Name: _________________________ **First Name:** _____________________________

Home Address: ____

City: _______________________________ **State:** _________ **Zip Code:** ______________

E-mail Address: _________________________

Telephone: ______________________________

Social Secuirty Number (For internal identification purposes only): _________________

Is this also your billing address: Yes: ______ **No:** ______

Business Information:

Name of Employer: ____

Title/Position: ____

Address: ____

City: _______________________________ **State:** _________ **Zip Code:** ______________

Is this also your billing address: Yes: ______ **No:** ______

Payment Information:

Type of Credit Card: Visa: ______ M/C: _______ Amex: ________ Other: _________

Credit Card Number: ____

Expiry Date: ____________________ Security Number: _________________________

I authorize use of my credit card: Yes: ______ No: ______

Signature: ____

OR

A check or money order for $999.00, made payable to the College of Mount Saint Vincent is enclosed: ______

How to submit completed registration form:

In person: 6301 Riverdale Avenue, Administration Building, Suite 304

By mail: Tamara Arbesman, Director, Marketing and Recruitment
College of Mount Saint Vincent
6301 Riverdale Avenue, Administration Bldg. Suite 304
Riverdale, NY 10471

By Fax: 718-405-3764

By E-mail: tamara.arbesman@mountsaintvincent.edu