



ASSOCIATES IN EMERGENCY CARE

AEC

PO Box 490

Damascus, MD 20872

<http://www.aecare911.org>

Email: aecare911@aol.com

Office: (301) 865-8880

Fax: (301) 865-8881

EMT-B/I/P Registration Form

Name (Last, First MI): _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: (Day) _____ **(Evening)** _____

Class and Location registering for: _____

Email address: _____

If paying by check or money order made out to Associates in Emergency Care mail this form with your payment to the address at the top of this form.

If paying by Visa or MasterCard, complete this information and fax or email the form. **Credit charges of \$500 or more will incur a processing fee of 2.5%

Card Number _____ **Amount \$** _____

Name as it appears on the card _____

Exp. Date (mm/yy) _____ **Please circle card type:**



Security Code (CVV) Three digit code on back of card _____

Cardholder's Signature _____

A non-refundable deposit for \$200.00 is required to reserve your place in the program. Fifty dollars can be refunded upon student's cancellation, 2 weeks before the start date of the class. This fee will be subtracted from your total tuition.