

## Registration Form

By completing the fields below, you will be registered for this class through [ilpathwaystohealth.org](http://ilpathwaystohealth.org).

\* Denotes required information

First Name\* : \_\_\_\_\_ Last Name\* : \_\_\_\_\_

Phone\* : \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth\* : \_\_\_\_\_

Address\* : \_\_\_\_\_

City\* : \_\_\_\_\_

State\* : \_\_\_\_\_ Zip\* : \_\_\_\_\_

### Health Insurance Information:

Health Insurance Provider: \_\_\_\_\_

Group ID: \_\_\_\_\_

Member ID: \_\_\_\_\_