

Registration Form

By completing the fields below, you will be registered for this class through ilpathwaystohealth.org.

* Denotes required information

Workshop ID*: _____

First Name*: _____ Last Name*: _____

Phone*: _____ Email Address: _____

Date of Birth*: _____

Address*: _____

City*: _____

State*: _____ Zip*: _____

Health Insurance Information:

Health Insurance Provider: _____

Group ID: _____

Member ID: _____