

CESAREAN SCAR REHABILITATION WORKSHOP REGISTRATION FORM

please mail or email in form and payment to reserve space

____ Saturday, March 3rd, 5-6:30pm, \$15*
**if you are unable to pay \$15, please come, and pay what you can*



Name: _____ Date of Birth: _____

Cesarean Date: _____

Address: _____

Telephone: _____ Cell _____

Email Address: _____

How did you hear about Motion Center? _____

Please list any injuries or health conditions you have had in the past 5 years. Please list any complications from the Cesarean that occurred and any issues you are currently experiencing.

I understand that I am registering for the Cesarean Rehabilitation workshop checked above. I have noted any injuries or health conditions I have, and have read and understand the Payment Policies.

signature

date

PAYMENT POLICIES:

Withdrawl 1 week prior to series start: full refund

Withdrawl less than one week before series start: \$5 refund

GENERAL INFORMATION: Please inform your teacher of any current/chronic injuries or health conditions so that she may safely modify the workshop for you.