

Smoking Cessation Training - Pacific Registration Form



Name

Organization or Company

.....

Position and Preferred Title

.....

Address

.....

Phone Fax

Mobile.....

Email

Preferred training dates.....
(Refer to flyer or Webpage)

Do you have any special need/s that would Yes No
require help?

Please advise:.....

.....

After the one day workshop we provide follow-up support for those who attend the training. **Please indicate how best to provide this service to you by circling Yes or No below:**

Coming to your workplace/organization Yes No

Support through emails Yes No

Support through phone calls Yes No

Providing you appropriate referral options Yes No

For further information contact:

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