

ASCENDED MASTERS FOUNDATION
The Divine Journey, October 30-November 1, 2009

REGISTRATION FORM

Name: _____

Street Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

E-Mail: _____

Name of Contact Person in Case of Emergency: _____

Emergency Contact Home Phone Number: _____

Emergency Contact Cell Phone Number: _____

Do you have any medical conditions that might affect your safety or completion of the Retreat? If so, please describe

Food Allergies or Food Restrictions:

Other Allergies:

Is there anything else you would like us to know for your safety and comfort?

During the event, we will be video taping, as well as taking photographs. Do we have your permission to use your image in future print material (e.g., advertising, newsletters)?

Yes No

Signature of Participant

Date