Dean & St. Mary's Health Works
A Service of Dean Health Plan

Registration Form

_____
Name (if under 18, provide age and legal guardian's name*)

_____
Address

_____
City, State and ZIP code

(____) _____ (____) _____ (____) _____
Home Phone Work Phone Cell Phone (optional)

_____@_____
Email Address

**minors may be required to provide parental consent before participating in a class.*

Are you a: *(check all that apply)*

- ☐ St. Mary's Hospital employee
- ☐ Dean employee
- ☐ GoldenCare Member
- ☐ Dean Health Plan Member

Course Title(s)	**Start Date**	**Time**	**Fee**
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____

Make checks payable to Dean & St. Mary's Health Works, except where noted.

Or, charge to: ☐ **MasterCard** ☐**Visa**

_____ _____
Card Number Expiration Date

_____
Signature

Please return form with payment to: Dean & St. Mary's Health Works

PO Box 56099, Madison WI 53705
Fax: (608) 830-5920