WILM
Western Institute of Legal Medicine

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Participant Information

Name: _____ Date: _____

Street Address: _____

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Telephone: ( ) _____ Fax: ( ) _____

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Circle Licensure: MD DO DPM DDS DCh PA RN LVN RPh Clin.Psych. Other _____

Organization/affiliation, if any: _____ Title: _____

Reason for taking program(s): _____

How did you hear about program(s)? _____

Instructions

Print and complete this form. Send to our address with your check for the programs you selected. Make your check out to the "Western Institute of Legal Medicine." Please note, your registration is not complete and we cannot hold room space for you until your check is received. For group discounts, you must register by telephone: (650) 212-4904

Mail completed form to:

Western Institute of Legal Medicine
1700 South El Camino Real, Suite 204
San Mateo, CA 94402