



Name of Workshop _____

Date _____

Payment Amount _____

Name: _____

Address: _____

City: _____

State-Zip: _____

Phone: _____

E-Mail: _____

Affiliation/ Company _____

Degree/ Lic. No. (if applicable): _____

Circle Form of Payment: check enclosed credit card

(If you are requesting CEs - please be sure to enclose the correct amount)

For Credit Card Payment: Visa MasterCard Discover

Card Number _____

Expiration Date _____

Amount _____

(Please be sure that your name and address match that of your credit card)

Mail to: InBalance Growth & Learning
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Santa Monica, CA 90405-3232
Phone (818) 754-4454
Fax: (818) 222-7514