



Application for the IPM Training Session

LOCATION: _____ DATE: _____

Section 1 – INFORMATION

Print Clearly in Ink

Name of Applicant (First & Last) _____		Phone: () _____
Date of Birth dd/mm/yy: _____		Fax: () _____
City/Town	Province & Postal code	Email:
Company Name (if applicable)		
Company Address		Company Telephone ()
City/Town	Province & Postal Code	Company Fax ()

Section 2 – PAYMENT

Payment amount: \$ _____ * Make cheque payable to: ***Plant Health Atlantic***
Do not mail cash.

Send to: **Ken Browne** Plant Health Atlantic Administrator
661 Route 8 Hwy **Taymouth, NB E6C 2C8**
Ph: 506 458-5365 **Fax: 506 472-4739**
Email: atlisnb2003@yahoo.com **Web Page PlantHealthAtlantic.ca**

*Training session registration fee is listed on the web page.

Office use only Date Received _____ Payment _____ IPM Training Dates: _____
