



**SAN BERNARDINO COMMUNITY COLLEGE DISTRICT
PROFESSIONAL DEVELOPMENT CENTER COURSE REGISTRATION**

114 S. Del Rosa Drive, San Bernardino, CA 92408, (909) 382-4075



Please fill out the registration form clearly and completely. You may register for more than one course, but only one person may register per form. **If you are under 18 years of age, your parent or guardian must sign in the place below.** Payment of all fees must accompany the registration form.

PRINT CLEARLY AND PRESS FIRMLY: CHECK ONE: ENGLISH ESPAÑOL

First Name-Nombre	Middle Initial	Last Name-Apellido

Street Number-Domicilio	Street Name-Callé	Apt.

City-Ciudad	State-Estado	Zip Code	

Social Security Number						

Telephone –Daytime: _____ Evening: _____ E-Mail-For On-line Courses: _____

COURSE NUMBER	COURSE TITLE	SESSION NUMBER	DATE OF ACTIVITY	FEE
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
TOTAL AMOUNT ENCLOSED:				\$ _____

MAKE CHECK OR MONEY ORDER PAYABLE TO "SBCCD"

RECEIPTS: If you wish to be mailed a receipt for payment, please attach a self-addressed, stamped envelope with this registration form and course fee payment. **REFUND POLICY:** No refunds are given for Professional Development Center courses or activities unless the classes are cancelled. You will be notified in the event of cancellation.

HOLD HARMLESS STATEMENT: I agree to hold Professional Development Center and the San Bernardino Community College District and all its officials and employees free and harmless from all legal action which may result from my, or my child's, attendance in the activities of Professional Development Center programs.

EMERGENCY MEDICAL RELEASE-Required for Participants Under 18 Years of Age: I understand that in case of an emergency requiring medical treatment for my child I may not be available to give my consent for such treatment, and therefore treatment may be withheld. Therefore, in case of injury to my child while attending any activity of the Professional Development Center program, I authorize any licensed physician, nurse, or hospital to render medical treatment to my child as may be necessary.

I certify that I am at least 18 years of age.

PLEASE SIGN HERE _____
 (Form Is Incomplete Without Signature) Signature of Adult Participant or Parent/Guardian of Minor Participant (under 18 years of age) Date-Fecha

FOR OFFICE USE ONLY	
Check No _____	ID _____

FOR CREDIT CARD USE	
Print Name of Card Holder _____	
Total Amount To Be Charged:	\$
Signature of Card Holder: _____	
Card Number: _____	
Circle One: MasterCard Visa Expiration Date: _____	