

REGISTRATION

NAME

First _____ Last _____ Date ____/____/____

ADDRESS

Street _____

City _____ State _____ Zip _____

E-MAIL ADDRESS

_____ Your email address allows WAE to send announcements.

PHONE

Home _____ Work _____ Cell _____

INDICATE YOUR METHOD OF PAYMENT

Exact Cash Check (# _____)

MAIL TO: Wallingford Adult Education

142 Hope Hill Road

Wallingford, CT 06492

PHONE: 203-294-5932

email: sgovin@wallingfordschools.org

CLASS DATE	COURSE TITLE	DAY	LOCATION	FEE

**TOTAL
DUE:** _____

REMEMBER:
a separate check
for each class.

**FOR ALL OTHER CONSUMABLE FEES, PAY THE INSTRUCTOR
IN CASH ON THE FIRST NIGHT OF CLASS.**