

TRIGENICS® SHOULDER SEMINAR REGISTRATION AGREEMENT

Registrant Information (please PRINT clearly)

First name: _____ Last name: _____ : Title: _____

DOCTOR / THERAPIST License # _____ Province: _____

STUDENT (Date of Graduation) mo/yr _____ / _____

Address: _____

City: _____

State: _____ Zip: _____ E-mail: _____

Phone(s): Work _____ Home: _____ Fax: _____

Special Bonus: Seminar attendees also get 15% discount on any Registered Trigenics Physician Condensed Internship Course (R.T.P.).

Credit Card Holder's Name: _____

(Circle) VISA/MC/AMEX #: _____ - _____ - _____ Exp. ____ / ____

I (we) hereby authorize the Trigenics Institute to debit my VISA, MasterCard, or American Express through paper or electronic entry, in the

Total amount of \$ _____

I certify that I have read and understand the terms of this agreement and the **Trigenics® Institute** rules and policies and agree to abide by such policies and acknowledge receipt of a copy of this agreement.

Print name: _____ Signature: _____

Date: _____

Term 1: The candidate acknowledges that "Trigenics®" is a proprietary registered trademark and treatment system with a patent pending on the procedures. They herewith agree to abide by all licensing requirements and to not use the Trigenics trademark without permission or a current R.T.P.® designation and prior written approval by The Trigenics® Institute. Any other use is prohibited by law with punitive damages.

Term 2: The candidate agrees not to divulge any specific information on the Trigenics® procedures to any other colleagues or health professionals without written approval by the Institute. Duplication of manual or audio/video material in any way is strictly prohibited and the undersigned hereby agrees not to copy any of the material.