BOMImed
Better Answers for Better Care

SERVICE TRAINING ENROLLMENT

Registration Information

Name: _____

Hospital Name: _____

Department: _____

Email: _____

Phone Number: _____

Course Selection:

☐ Hamilton G5 ☐ Hamilton C1/C2/T1/MR1 ☐ Atom Infa Warmer

☐ Medin CNO ☐ Atom Dual/Incu i

Dates of Course: From: _____ To: _____

Method of Payment

☐ PO# _____ (attach copy) ☐ Training included with equipment purchase PO# _____

Credit Card: ☐ Visa ☐ MasterCard

Credit Card #: _____

Expiry Date: _____

Card Holder Name: _____

Allergies (please list any food allergies below):

To ensure proper confirmation of enrollment, the completed form MUST be emailed to service@bomimed.com or faxed to 1-877-435-6984

_____ _____

Signature Date

1-100 IRENE STREET
WINNIPEG, MB
R3T 4E1

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