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## ADULT WORKSHOP REGISTRATION FORM

<b>NAME:</b>		<b>HOME PHONE:</b>	
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<b>CITY:</b>		<b>EMAIL:</b>	
<b>POSTAL CODE:</b>		<b>EMERGENCY CONTACT:</b>	

<b>PROGRAM NAME:</b>	
<b>DAY:</b>	
<b>TIME:</b>	

I CONSENT TO RECEIVE EMAIL COMMUNICATION FROM TO THE STARS OT AND WELLNESS CENTRE REGARDING UPCOMING PROGRAMS AND NEWSLETTERS.

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SIGNATURE

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DATE

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