

# REGISTRATION

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**NAME**

First \_\_\_\_\_ Last \_\_\_\_\_

**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:** sgovi@wallingfordschools.org

CLASS DATE	COURSE TITLE	DAY	LOCATION	FEE

**TOTAL DUE:** \_\_\_\_\_

**REMEMBER:**  
a separate check  
for each class.

• MAKE CHECKS PAYABLE TO WALLINGFORD ADULT EDUCATION.  
• FOR CONSUMABLE FEES, PAY THE INSTRUCTOR  
IN CASH ON THE FIRST NIGHT OF CLASS.

