

**Academy of Continuing Education, Inc.**  
**Provider ID #: 124289 – all Non-Company/Non-Agency courses**  
**P.O. Box 117, Altavista, VA 24517-0117 Phone: 434-237-0991 Office fax: 434-385-6837**

**LYNCHBURG CONTINUING EDUCATION CLASSES**

**Location: Training Rm. 19220 Forest Road [Rt. 221] Lynchburg, VA 24502 located behind  
Davis Heating & Cooling, Inc. Phone: 434-385-0080**

**DAY- Cost \$30.00**

**Class Date: Monday March 18, 2013 – Health Care Reform - 203550**

**PPACA & Reconciliation Act**

**Class Hours: 9:20 a.m. Registration 9:35 a.m. – 1:30 p.m. CLASS [4 credits – 4 ILR]**

Class Reservation & Pre-Enrollment

**CLASS Date: Monday March 18 CLASS Location: 19220 Forest Rd. Lynchburg, VA 24502**

**Health Care Reform 203550**

Please print the requested information, leave blank what does not apply. This form must be returned to reserve a space in the class. Enclose a check for your cost, made payable to **Academy of C. E., Inc.**

FULL NAME: \_\_\_\_\_ License. #: \_\_\_\_\_

RES. ADDRESS: \_\_\_\_\_ PHONE # \_\_\_\_\_

CITY/TOWN \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ - \_\_\_\_\_

Payment [due with enrollment form] Amount: \$ \_\_\_\_\_, **to put on a Credit Card** complete below:

Credit Card #: \_\_\_\_\_ Exp. Date \_\_\_\_\_ [mo/year]

Three or four digit number [last numbers] on back of credit card **different from card #**: \_\_\_\_\_

Type of card [check one]:  **Discover**  **Master Card**  **Visa**

Cardholder Signature \_\_\_\_\_ [print name] \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Agent's Signature

**Mail or e-mail this form to: Academy of Continuing Education, Inc.**  
**P.O. Box 117, Altavista, VA 24517-0117 Office phone: 434-237-0991**

**E-mail to: [academyofce@aol.com](mailto:academyofce@aol.com)**