Mini Medical School: Medical Science and Aging, 2019
Day-of Registration Form

Date: _____

First Name: _____ Last Name:_____

e-mail:_____ Cell Phone or Home Phone: _____

Mailing Address (Street, City, State, Zip Code):

_____

Gender (not required) ☐ Male ☐ Female ☐ Decline to State ☐ Prefer to describe: _____

Age (not required):_____

Have you attended the College of Marin Mini Medical School in the past?

- ☐ Yes, in 2015
- ☐ Yes, in 2016
- ☐ Yes, in both 2015 and 2016
- ☐ Yes, in both 2016 and 2018
- ☐ Yes, in 2015, 2016 and 2018
- ☐ No

How did you hear about this event?

- ☐ Friend or community member
- ☐ Organization newsletter
- ☐ College of Marin website
- ☐ College of Marin e-mail
- ☐ Social Media (Facebook, Twitter, Instagram)
- ☐ Other (Please explain.) _____

Thank you for registering for Mini-Medical School at the College of Marin.