

F.U.N. & S.N.A.P. Registration

Child's Name _____ Date of Birth _____

Parent/Guardian _____

Address _____

Phone Number (H) _____ (W) _____

Email Address _____

PLEASE MARK WHICH SESSION YOU WOULD LIKE TO ENROLL YOUR CHILD:

SESSION DATES	F.U.N. (ages 7-11) 9:00 AM	S.N.A.P. (ages 12 to 15) 10:00 AM
Jan 17 to Feb 21, 2009		
April 25 – June 6		
July 25 – August 29		
October 17 – November 21		

PAYMENT METHOD:

Check (Make payable to Inova Fair Oaks Hospital and mail to address below)

Credit Card

VISA

MasterCard

American Express

Card # _____ Exp. Date _____ Security # _____

ON BACK

FAX TO: (703) 391-3207

OR

MAIL TO: Inova Fair Oaks Hospital,
3600 Joseph Siewick Drive, Fairfax, VA 22033

ATTN: Nancy Golden



**INOVA® FAIR OAKS
HOSPITAL**