BOMImed
Better Answers for Better Care

SERVICE TRAINING ENROLLMENT

Registration Information

Name: ____________________

Hospital Name: ____________________

Department: ____________________

Email: ____________________

Phone Number: ____________________

Course Selection:

☐ Hamilton G5 ☐ Hamilton C1/T1/MR1 Atom Infa Warmer

☐ Medin CNO ☐ Atom Dual/Incu i Hamilton C6

Dates of Course: From: ____________________ To: ____________________

Method of Payment

☐ PO# ____________ (attach copy) ☐ Training included with equipment purchase PO# ____________

Credit Card: ☐ Visa ☐ MasterCard

Credit Card #: ____________________

Expiry Date: ____________________

Card Holder Name: ____________________

Allergies (please list any food allergies below):

To ensure proper confirmation of enrollment, the completed form MUST be emailed to service@bomimed.com or faxed to 1-877-435-6984

Signature ____________________ Date ____________________

1-100 IRENE STREET
WINNIPEG, MB
R3T 4E1

T. 800.667.6276
F. 877.435.6984
E. info@bomimed.com

www.bomimed.com