



Mental Health First Aid Supporting Youth

Registration Application

Applicant Name: _____ (First) _____ (Last)

Faculty/ Admin. Unit: _____

Position: _____

Campus Address: _____

Campus ph. #: _____ UM Email: _____

Training Dates: Monday, April 20 (9:00-1:00) and Tuesday, April 21 (9:00-1:00)

Cost: \$200.00 ****This is non-refundable once code has been provided to participant****

Note: the cost of your participation is covered by the FKRM Endowment Fund

X _____
Applicant Signature Date

X Financial Signing Authority Signature Financial Signing Authority Name and Title (please print) Date

****This is non-refundable once code has been provided to participant****