PLEASE RETURN THIS DOCUMENT WITH YOUR COMPLETION CERTIFICATE

PLEASE COMPLETE THIS FORM LEGIBLY

PARTICIPANTS FULL NAME:_____

DEALERSHIP NAME:_____

DEALERSHIP ADDRESS:_____

CITY:_____**ZIP CODE:**_____

DEALER NUMBER: _____ **PHONE NUMBER: ( )**_____

ATTENDEE'S POSITION IN DEALERSHIP _____
(i.e.: Owner, Partner, Managing Member * Corporations – President, Treasurer etc)

SALESPERSON LICENSE NUMBER:_____**EXPIRES:**_____

COMPLETION DATE OF YOUR HOME STUDY:_____

ADDRESS WHERE YOU WANT THE CERTIFICATE MAILED IF DIFFERENT

FROM ABOVE:_____

CITY:_____**ZIP CODE:**_____

EMAIL ADDRESS: (OPTIONAL)_____