

Institute of Excellence for the Health Science Cluster
November 17-19,2005 Or February 9-11,2006 (circle one)

Name: _____

School Name: _____

School Address: _____

School Phone: _____ School E-mail: _____

Home E-mail: _____ Subjects taught: _____

If applying for the Master Teacher Certificate, I agree to:

- Attend the Institute
- Participate in regular communications and electronic meetings
- Develop and submit a portfolio of work
- Attend the National Health Science Curriculum Conference - October, 2006
- Participate in a twenty-hour externship in a health care or bioscience setting

Maps and Logistical information will be sent along with the confirmation.

Registration Fee: \$450

____ Check ____ School PO ____ Credit Card MC Visa

Signature: _____

Card # _____ Exp _____

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Mail To: NCHSTE
2410 Woodlake Dr.
Okemos, MI 48864
OR
Fax: 517-347-4096
Phone: 517-347-3332