

## CONFIRMATION & CANCELLATION

A confirmation notice will be sent to you within 10 days of receipt of your registration form and full payment. If you do not receive your confirmation within this timeframe, please contact us at 780-498-3363.

**Cancellations/Substitutions:** Registration cancellations received up to 5 business days prior to the workshop are refundable, minus a \$25 cancellation fee. After that, cancellations are subject to the entire workshop fee. Please note, if you do not cancel and do not attend you are still responsible for the entire registration fee. Substitutions may be made at any time.

For a list of all Millard Health workshops, visit our website at:

<http://www.millardhealth.com>

## REGISTER BY

**FAX:** 780-498-3819

**PHONE:** 780-498-3363

**MAIL:** Millard Health Workshops  
131 Airport Rd  
Edmonton AB T5G 0W6

# 2010 Industrial Ergonomics Workshop



## WORKSHOP

This full-day workshop is intended to assist employers in developing strategies to reduce worker discomfort related to poor ergonomics and improve individual and organizational efficiency.

This workshop will help employers working in manufacturing, engineering and construction settings. You will learn evaluation techniques to adapt job tasks to the worker's ability. In a group case study format, you will also learn proper manual handling techniques, evaluate job tasks, equipment and workplace design. Studies show that workers who are taught how to safely perform their job greatly reduce their risk of injury.

This workshop is designed for supervisors, human resources staff and health and safety individuals responsible for ergonomics.

## DATES & LOCATIONS

### EDMONTON: 8:00 - 4:30 P.M.

MILLARD HEALTH  
131 AIRPORT RD

- { } FEB 10
- { } MAR 24
- { } JUN 16
- { } SEPT 21
- { } NOV 17
- { } DEC 1

### CALGARY: 8:00 - 4:30 P.M.

MCCALL COURT  
150, 4311 12 STREET NE

- { } APR 21
- { } OCT 20

\$400.00 (+ GST = \$420.00)  
Includes workshop, materials,  
continental breakfast.

## REGISTRATION

NAME

COMPANY

EMPLOYER WCB ACCOUNT NUMBER

TITLE

ADDRESS

CITY/PROV/PC

EMAIL

( )

( )

PHONE

FAX

{ } VISA { } MASTERCARD { } CHEQUE ( PAYABLE TO MILLARD HEALTH )

CARD #

EXPIRY DATE (MM/YY)

NAME ON CARD (IF DIFFERENT FROM ABOVE)

SIGNATURE

\*By signing, I authorize the use of my credit card for the payment of this workshop