

## 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 Office Ergonomics Workshop



## WORKSHOP

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

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

Learned strategies will include:

- ~ Short term interventions such as identifying workplace hazards with minimal modification
- ~ Long term strategies that enable one to accommodate injured and special needs employees
- ~ Providing information on basic health related issues

The small group sessions are interactive in nature.

## DATES & LOCATIONS

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

MILLARD HEALTH  
131 AIRPORT RD

- { } FEB 9
- { } MAR 23
- { } JUN 15
- { } SEPT 20
- { } NOV 16
- { } NOV 30

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

MCCALL COURT  
150, 4311 12 STREET NE

- { } APR 20
- { } OCT 19

\$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