

Information Change Form

Fill out the information below and return by fax or mail.

Fax 707-307-5017

Boston Reed College
2799 Napa Valley Corporate Drive
Napa, CA 94558

Current Information:

Name: _____

Address: _____

City: _____ State _____ Zip _____

Phone: _____ Cell: _____

Fax: _____ Work: _____

Email: _____

New Information:

Name: _____

Address: _____

City: _____ State _____ Zip _____

Phone: _____ Cell: _____

Fax: _____ Work: _____

Email: _____

Program Enrolled in:

- | | | |
|--|--|--|
| <input type="checkbox"/> Clinical Medical Asst. | <input type="checkbox"/> EKG | <input type="checkbox"/> Vocational Nursing |
| <input type="checkbox"/> Administrative Med. Asst. | <input type="checkbox"/> Pharmacy Tech | <input type="checkbox"/> Optometric Technician |
| <input type="checkbox"/> Orthopedic Technician | <input type="checkbox"/> Phlebotomy | |

Start Date: _____ Location: _____

Signature: _____ Date: _____