



Technical Training Registration Form

For all Technical training - Fax to **800-445-9967**

Includes: HCIS/PACS/RIS/IMS/CR/DR/DO

Questions regarding Technical Training call 800-810-0327 option 3

(To be completed by Attendee's Manager – Please print clearly or type information)

| | | |
|---|-------------------|-------------------------|
| Attendee's Name | | |
| Company Name | | |
| Company Mailing Address | | Student Mailing Address |
| City | | City |
| State, Zip Code | | State, Zip Code |
| Attendee's Phone Number | | Fax Number |
| Attendee's Email Address | | |
| | | |
| Class Selection | Class Name | Class Date |
| First Choice | | |
| Second Choice | | |
| | | |
| Is the Attendee a direct employee of the Company noted above? (mark yes or no) | Yes | No |
| If not, who is the Attendee's employer? | | |
| | | |
| Attendee Technical Training Agreement | | |
| <ol style="list-style-type: none"> 1. All information (including but not limited to data, know-how, trade secrets, methods, resources, tools, designs and procedures) provided to the Attendee in connection with the technical training course is the property of Carestream Health, Inc. ("Carestream Health") 2. This information shall remain the property of Carestream Health and shall only be used by the Attendee in connection with the operation, service, repair or maintenance of Carestream and Kodak medical imaging equipment. 3. Attendee understands the proprietary nature of the information and agrees to take every reasonable precaution to protect such information from disclosure to third parties. Attendee will not copy or reproduce any material provided to Attendee in connection with the technical training course. 4. In the event that the Attendee severs relationship with the employer noted within this document and/or Carestream Health, Attendee shall immediately cease using the above described information and such information shall be returned immediately to Carestream Health. 5. Attendee agrees to indemnify Carestream Health against any losses incurred by Carestream Health, including reasonable counsel fees resulting from the breach of any provision of this agreement by Attendee. 6. I have read and understand all of these requirements and responsibilities that accompany any Carestream Health technical training and agree to the terms and conditions herein. 7. I acknowledge that I have read the technical training course description and meet all of the prerequisites to attend the class. | | |
| Attendee's Signature _____ | | |
| Manager's Signature | | Date |
| Print Name | | Manager's Email Address |

Carestream Health Office Use Only:

Quote Number:

PM Name: