

# Tai Chi Center

## Integrated Center for Oriental Medicine

Name:\_\_\_\_\_ Address:\_\_\_\_\_

City:\_\_\_\_\_ State:\_\_\_\_\_ Zip:\_\_\_\_\_

Phone:\_\_\_\_\_

E-mail:\_\_\_\_\_

I would like to register for the following classes:

Course	Tuition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I am a new student to the Tai Chi Center (\$15.00 fee) Total: \_\_\_\_\_

Please make checks out to: **Tai Chi Center**

Please enclose your check made out for the total dollar amount and mail to:

**Integrated Center for Oriental Medicine**

5924 W. Parker Rd., Suite 100

Plano, TX 75093

All classes are held at the Center, if you have any questions please feel free to give us a call at: (972) 473-9070.

*Integrated Center for Oriental Medicine*  
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(972) 473-9070