

Cosmopolitan Ballet Theatre  
121 Whitmoor Terrace,  
Silver Springs, MD 20901

**Cosmopolitan Ballet Theatre  
Summer Intensive 2024  
STUDENT REGISTRATION FORM**

I Will Attend:  
Group 1 June 4 – 15, 2024   
Group 2 June 17 – July 6, 2024   
Group 2 July 8 – 20, 2024

Please print and return this form along with a non-refundable deposit of \$500 to the address above by January 15, 2024

Today's Date:

**APPLICANT INFORMATION**

Applicant's Last Name:		First:	Middle:	Age at start of workshop:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date:
Applicant's Street Address:				Home Phone No.: ( )	Cell Phone No.: ( )	
P.O. Box:	City:		State:		ZIP Code:	
Parent I/Guardian's Last Name:		First:	Middle:	Home Tel: ( )	Work Tel: ( )	Cell Tel: ( )
Parent II/Guardian's Last Name (if applicable):		First:	Middle:	Home Tel: ( )	Work Tel: ( )	Cell Tel: ( )
Parent I/Guardian's Email Address:		Parent II/Guardian's Email Address:		Person Responsible For Tuition & Fees:		
Please List Ballet Schools Attended:				Please Indicate Years Of Dance Experience:		
Are there any issues or pre-existing conditions that may affect training? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please describe briefly:				
Please tell us how you heard about our program: <input type="checkbox"/> Friend <input type="checkbox"/> Teacher <input type="checkbox"/> Web Site <input type="checkbox"/> Facebook <input type="checkbox"/> Other _____						

**HEALTH INSURANCE INFORMATION**

Is this applicant covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance:		Name of health insurance provider:				
Subscriber's name:		Subscriber's group no.:		Subscriber's policy no.:		
Applicant's relationship to subscriber:		<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other				
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:		Policy no.:
Applicant's relationship to subscriber:		<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other				

**IN CASE OF EMERGENCY**

Name of local friend or relative (not living at same address):		Relationship to applicant:	Home phone no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge.				
<i>Patient/Guardian signature</i>			<i>Date</i>	