

**Introductory Workshop
February 10 - 11, 2023**

Registrant:

Title: Dr. Mr. Mrs. Ms

Name: _____

Payment:

Cheque enclosed

Already paid online

Virtual Terminal payment option:

Visa MasterCard

Card Number:

Expiry: Month Year

Three-digit security code (back of card)

Amount authorised or paid: \$ _____

Cheques payable to CSCH-OD

(No post-dated cheques please.)

Mail to:

CSCH-OD Introductory Workshop

2321 Av. Regent, Montreal, QC

H4A 2R2

To benefit from the Early Bird price, both the completed registration form and payment must be received no later than 6 p.m. on the day of the deadline.

Enrollment may be limited so please submit your registration form as soon as possible.

Registration Form

Email Address (required): _____

Mailing Address: _____

This is my: home address office address

Phone number: _____ Highest degree: _____

I want to be in the: psychotherapy stream medical stream

I am a licensed, registered professional.

I am a member in good standing of the (college) _____
(e.g. CPSO, CPO, OCSWSSW, CRPO, CNO, etc.)

License/registration number: _____

Or

I am a student or medical resident. I have read the eligibility requirements on the website and I am eligible for the student rate. I have attached proof of enrollment.

Course and school: _____

Graduation/completion date (year): _____

I confirm the accuracy of the information provided.

Registrant's Signature

