

# Introductory Workshop

## March 1 & 2, 2024

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  
705, 20 Aurora Crt, Scarborough, ON  
M1W 2M2

To benefit for the Early Bird rate, both the completed registration form and payment must be received by 6 p.m. on the day of the deadline.

### 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 my current enrollment.

Program and school: \_\_\_\_\_

Graduation/completion date: \_\_\_\_\_

I confirm the accuracy of the information provided: \_\_\_\_\_

Registrant's signature

