Introductory Workshop
April 25 and 26 2025

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

CSCH Ontario Division