

# **REGISTRATION FORM**

## **The Revised Second Edition ASAM Patient Placement Criteria Ray Caesar, LPC, LADC**

### **HOW TO REGISTER**

#### **By Mail:**

ODMHSAS, Human Resources Development  
2401 NW 23rd Street, Suite 1F  
Oklahoma City, OK 73107

**By Fax:** Faxed registrations are accepted at 405-522-8320  
For information, call Human Resources Development at 405-522-8300.

### **REGISTRATION INFORMATION:**

**Name:** \_\_\_\_\_  
**Home Phone Number:** \_\_\_\_\_  
**Occupation or Job Title:** \_\_\_\_\_  
**Place of Employment:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State, ZIP:** \_\_\_\_\_  
**Daytime Phone:** \_\_\_\_\_  
**E-Mail Address:** \_\_\_\_\_

\*\*Note: If an e-mail address is included, a confirmation that your registration has been received will be e-mailed to you.

I require special accommodations as follows: \_\_\_\_\_  
\_\_\_\_\_

### **PLEASE CHECK ONE TRAINING DATE**

#### **Oklahoma City**

- January 13, 2014
- February 24, 2014
- March 31, 2014
- April 28, 2014
- May 19, 2014
- June 16, 2014

#### **Woodward**

- January 28, 2014

### **PAYMENT**

Please enclose registration payment. If paying by purchase order (PO), please mail or fax a copy of the purchase order with the name of the attendee(s) included on the PO. If paying by check or money order please make payable to ODMHSAS. Please check all boxes that apply. No Refunds.

<b>FORM OF PAYMENT</b>	<b>EARLY BIRD RATE (One calendar week or more before start date)</b>	<b>REGULAR RATE</b>	<b>ODMHSAS EMPLOYEE</b>
<input type="checkbox"/> Check or Money Order	<input type="checkbox"/> \$85	<input type="checkbox"/> \$135	<input type="checkbox"/>
<input type="checkbox"/> Purchase Order # _____	<input type="checkbox"/> \$85	<input type="checkbox"/> \$135	
<input type="checkbox"/> Credit Card (circle one): <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard			
Credit card # _____	Expiration Date: _____	Cardholder signature: _____	

### **CONTINUING EDUCATION CREDIT REQUESTED**

- |                                    |                               |                               |                                       |                                    |  |
|------------------------------------|-------------------------------|-------------------------------|---------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> LPC  | <input type="checkbox"/> LMFT | <input type="checkbox"/> Psychologist | <input type="checkbox"/> CPS       | <input type="checkbox"/> Under Supervision |
| <input type="checkbox"/> PRSS      | <input type="checkbox"/> CADC | <input type="checkbox"/> LADC | <input type="checkbox"/> LCSW         | <input type="checkbox"/> Case Mgmt | <input type="checkbox"/> Other _____       |

