

**Registration Form**  
**2013 Ethical Dilemmas When Meeting Mental Health Care Needs**  
**December 2, 2013**

**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

**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 one week before the training.

I require special accommodations as follows:

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE SELECT A SESSION**

9:00 – 12:00

1:00 – 4:00

**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>ODMHSAS EMPLOYEE</b>	<b>REGULAR RATE</b>
<input type="checkbox"/> Check or Money Order	<input type="checkbox"/>	<input type="checkbox"/> \$45
<input type="checkbox"/> Purchase Order # _____		<input type="checkbox"/> \$45
<input type="checkbox"/> Credit Card (circle one): <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard		<input type="checkbox"/> \$45
Credit card # _____	Expiration Date: _____	Cardholder signature: _____

**CONTINUING EDUCATION CREDIT REQUESTED**

LPC       LMFT       Psychologist       LADC       Under Supervision  
 PRSS       CADC       LADC       LCSW       CM       Other \_\_\_\_\_

For information, call Human Resources Development at 405-522-8300.