Clinician’s Corner On-site Workshop Enrollment Form

Please Print Clearly

Name ____________________________________________________ □ PhD □ PsyD □ EdD □ Other ________
(Last) (First) (Mi)

APA MEMBER? □ YES, #___________________ □ NO

STREET ADDRESS _______________________________________________________________________

CITY/STATE/ZIP______________________________________________________________

PHONE DAYTIME (____) ________-_____________ E-MAIL ADDRESS ______________________________

ARE YOU A PSYCHOLOGIST? □ YES □ NO IF YES, IN WHAT STATE? ______________________

WORKSHOP DATE WORKSHOP TITLE FEE

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

TOTAL ENCLOSED OR TO BE CHARGED TO YOUR CREDIT CARD $________________

METHOD OF PAYMENT

1) CHECK—DRAWN ON A U.S. BANK IN U.S. DOLLARS TO “APA.” CHECK #___________________

2) CREDIT CARD (COMPLETE INFORMATION BELOW IN FULL.)

I AUTHORIZE APA TO CHARGE MY WORKSHOP FEE(S) TO MY CREDIT CARD AS LISTED BELOW.

CREDIT CARD: □ AMERICAN EXPRESS □ MASTERCARD □ VISA

ACCOUNT# __________________________________________________________

EXPIRATION DATE _______ / ________

CARDHOLDER NAME _______________________________________________________
(Last) (First) (Mi)

PHONE DAYTIME (___________) _______________-_______________

CREDIT CARD BILLING ADDRESS (ONLY IF DIFFERENT FROM ABOVE)

STREET ADDRESS __________________________________________________________

CITY/STATE/ZIP______________________________________________________________

SIGNATURE (REQUIRED) __________________________________________ DATE ________________

MAIL TO:
APA ACCOUNTING/CEP OFFICE
CLINICIAN’S CORNER ENROLLMENT
750 FIRST STREET, NE
WASHINGTON, DC 20002-4242

FAX TO: (202) 336-6151

For APA accounting use only:
44010–401380-MGR-CMTYWS