



Clinician's Corner 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:
4200-40138-MGR-CMTYWS