

# REGISTRATION FORM

## Correct Administration and Application of the Addiction Severity Index (ASI)

### 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.

**By Email:** Completed forms may be emailed to [jeiones@odmhsas.org](mailto:jeiones@odmhsas.org).

### REGISTRATION INFORMATION:

**Name:** \_\_\_\_\_

**Home Phone Number:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_

**Place of Employment:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, ZIP:** \_\_\_\_\_

**Daytime Phone:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_

If an e-mail address is included, a confirmation that your registration has been received will be e-mailed to you **one week prior to the training**.

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

### DATES

January 12-13, 2015 – Oklahoma City

March 5-6, 2015 – Tulsa

May 4-5, 2015 – Oklahoma City

### 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.

FORM OF PAYMENT	EARLY BIRD RATE	REGULAR RATE	ODMHSAS EMPLOYEE
<input type="checkbox"/> Check or Money Order	<input type="checkbox"/> \$170	<input type="checkbox"/> \$220	<input type="checkbox"/>
<input type="checkbox"/> Purchase Order # _____			
<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

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