

REGISTRATION FORM

**Addiction Severity Index (ASI)
Up-Date Training**

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 jejones@odmhsas.org.

REGISTRATION INFORMATION:

Name: _____

Home Phone Number: _____

Occupation or 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

February 2, 2015 - Oklahoma City

April 10, 2015 - Tulsa

June 8, 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"/> \$85 | <input type="checkbox"/> \$135 | <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 _____