2010 Mental Health Professionals Collaboration
Thursday, April 29, 2010

Registration Form

Please complete the information below:

Name: ____
(As you want it to appear on your nametag)

Credentials: ____

Organization/Agency: ______________________________________

Address: ____

City: __________________ State: ____________ Zip: _____________

Phone Number: ______________________ Last 4 Digits of SS#: ______________

Email Address: ____

Payment Method ($75):

- ☐ **Visa** **Number: ______________________ Expiration Date: _____**
- ☐ **MasterCard** **Number: ______________________ Expiration Date: _____**
- ☐ **AmEx** **Number: ______________________ Expiration Date: _____**
- ☐ **Check # _______________**
- ☐ **Purchase Order**
- ☐ **IIT**

Please select the type(s) of credit you wish to receive:

- ☐ **LPC, LMFT, LPES - 7 hours of CE credit**
- ☐ **Psychologists - 7 Category A credits**
- ☐ **Social Workers - 7 hours of general credit**
- ☐ **Other - .7 Continuing Education Units**

Please indicate any special needs (dietary or physical) or comments below:

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Please return the completed form with payment to:
MUSC Psychiatry – Post Graduate Education Office
51 Bee Street; MSC 861
Charleston, SC 29425
Fax (843) 792-7298