REGISTRATION FORM

Please enroll me in the following workshop(s): ✔

☐  **Workshop A:** Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Children, ages 6-12 (Ehrenreich-May; 3 hours of CE)
   Friday, October 12, 2018  8:45 AM - 12:00 PM

☐  **Workshop B:** Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Adolescents (Ehrenreich-May; 3 hours of CE)
   Friday, October 12, 2018  1:00 PM - 4:15 PM

☐  **Workshop C:** Ethical Issues and Decision Making in Psychological Practice with Older Adults (Dotson; 3 hours of Ethics CE)
   Friday, October 19, 2018  8:45 AM - 12 PM

☐  **Workshop D:** Sexual Harassment and Assault: The Social Context of Trauma and Ethical Considerations for Treatment (Orchowski; 3 hours of Ethics CE)
   Friday, October 19, 2018  1:00 PM - 4:15 PM

**Workshop Fee Schedule**

*Early Registration*: early registration (received or postmarked by 9/28/18) for one workshop is $70; two workshops is $130; three workshops is $190; and four workshops is $250.

*Regular Registration*: registration (9/29/18 and after) for one workshop is $80; two workshops is $150; three workshops is $220; & four workshops is $290.

*Students/Interns/Postdocs*: the cost for students, interns, and psychology postdoctoral fellows is $30 per workshop (documentation of status required).

**Cancellation Policy**

To cancel, call 404-413-6229. Refunds will be granted minus a $35 fee per workshop ($15 for students/interns/postdocs) if notification is received at least 7 days before each workshop. No refunds will be given after that time. For returned checks, a $30 fee will be charged.

**Total Cost for Workshop(s):** $___________________

Please check appropriate box:

___Psychologist  ___Professional Counselor  ___Student/Intern/Postdoc

___Other Professional _____________________________________________
Name: __________________________________________________________

Address: _________________________________________________________

(If using credit card, please indicate your billing address here)

City: ____________________________ State: _____ Zip: _______________
Telephone #: ______________________ Fax #: ________________________

Email address: ____________________________________________________

Method of Payment: ¨ Check  ¨ MasterCard  ¨ Visa

Credit Card #: ____________________________________________________

(Please be sure to indicate your credit card billing address above.)

Expiration Date (MM/YY): _________________________________________

Total Amount: $____________________________________________________

Signature: ________________________________________________________
(required for those paying by credit card)

Make check payable to GSU.

MAIL this form and payment to:  GSU Psychology Clinic
PO Box 5010
Atlanta, GA 30302-5010

Or,

FAX with credit card info to 404-413-6589. Call to confirm receipt of fax: 404-413-6229.