



Behavioral Tech Two-Day Training Registration

Registration Information

Today's Date: _____ Training Location: _____

Primary Contact Information:

Name: _____ Credentials (i.e. LPC, LCSW) for CE/CME: _____ Degree: _____

Agency _____

Address _____ City, St., Zip _____

Phone _____ Fax _____

Email _____

Sign me up to receive Behavioral Tech mailings (mailing address required)

Payment Information and Remittance Information

Return the Form with payment information to:

Behavioral Tech
Attn: Registration
2133 Third Avenue, Suite 205
Seattle, WA 98121

FAX: 206 675 8590

Date: _____ CREDIT CARD CHECK ENCLOSED

VISA/MC/DISCOVER
Credit Card Number _____

Exp . Date: _____ Name on Card _____

Amt. to Charge _____

When we have received your payment and registration information, you will receive an email with confirmations for the members of your group and directions to the event.

Please call the Customer Care Coordinator at 206.675.8588 ext 121 if you have questions or require assistance

Group Members Names and Contact Information

1. Name: _____ Credentials (i.e. LPC, LCSW) for CE/CME: _____ Degree: _____

Agency _____

Address _____ City, St., Zip _____

Phone _____ Fax _____ Email _____

2. Name: _____ Credentials (i.e. LPC, LCSW) for CE/CME: _____ Degree: _____

Agency _____

Address _____ City, St., Zip _____

Phone _____ Fax _____ Email _____

Group Members Names and Contact Information (continued)

3. Name: _____ Credentials (i.e. LPC, LCSW) for CE/CME: _____ Degree: _____ Agency _____ Address _____ City, St., Zip _____ Phone _____ Fax _____ Email _____
4. Name: _____ Credentials (i.e. LPC, LCSW) for CE/CME: _____ Degree: _____ Agency _____ Address _____ City, St., Zip _____ Phone _____ Fax _____ Email _____
5. Name: _____ Credentials (i.e. LPC, LCSW) for CE/CME: _____ Degree: _____ Agency _____ Address _____ City, St., Zip _____ Phone _____ Fax _____ Email _____
6. Name: _____ Credentials (i.e. LPC, LCSW) for CE/CME: _____ Degree: _____ Agency _____ Address _____ City, St., Zip _____ Phone _____ Fax _____ Email _____
7. Name: _____ Credentials (i.e. LPC, LCSW) for CE/CME: _____ Degree: _____ Agency _____ Address _____ City, St., Zip _____ Phone _____ Fax _____ Email _____
8. Name: _____ Credentials (i.e. LPC, LCSW) for CE/CME: _____ Degree: _____ Agency _____ Address _____ City, St., Zip _____ Phone _____ Fax _____ Email _____

Please photocopy form as needed