



NON-MEMBER REGISTRATION FOR CONTINUING EDUCATION UNITS

Please print

Event Name _____ Date _____

Name _____

Address _____

Daytime Phone _____

Evening Phone _____

License Number _____

E-mail _____

Credits are for: (check one)

- Psychiatrist or Physician (C.M.E.)
- Psychologist
- Ohio Licensed Counselor/Social Worker

PROOF OF PARTICIPATION WILL BE
ISSUED AFTER THE PROGRAM BY MAIL
FROM THE CENTER ADMINISTRATIVE
OFFICE

Enclosed is my check for _____ credits at \$15.00 per credit hour, payable to the Cleveland Psychoanalytic Center*

Please charge my credit card for _____ credits at \$15.00 per credit hour:

Name on Card (Please print) _____

Card Number _____ Expiration Date _____

Mail registration form with payment to:
Cleveland Psychoanalytic Center
2460 Fairmount Blvd., Suite 312
Cleveland Heights, OH 44106

or

Fax registration form with credit card info to:
(216) 229-7321
Attn: Debbie Morse, Administrative Coordinator