**Intensive Four-Day Workshop in**

**Exposure and Response Prevention (ERP) for**

**Obsessive-Compulsive Disorder (OCD)**

***July 16-19, 2018***

**Registration Form**

|  |  |
| --- | --- |
| **Last Name:** | **First Name:** |
| **Work Agency:** | **Profession:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Work Address:** | **City:** | **State:** | **Zip:** |
| **Work Phone:** | **Ext:** |  |  |
| **Home Address:** | **City:** | **State:** | **Zip:** |
| **Email Address:** |  |  |  |

**Briefly describe prior treatment experience:**

|  |
| --- |
| **Fee: - $1,500**  **Form of Payment** |
| **Check** |
| **Please make check or money order payable to “CPUP” and mail to:** Center for Treatment &  Study of Anxiety, ATTN.: Cheryl Samuels, 3535 Market Street, 6th Floor, Philadelphia, PA 19104 |
| **Credit Card (VISA, MC, Discover) – no AMEX is accepted**    **Name as it appears on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_ Sec. #: \_\_\_\_** |

*Please note: There is limited space available, so please reserve your space early.*