

**New York Mental Health Counselors Association
Licensure Examination Preparation Workshop Registration**

*** Please Print ***

Title: (Dr./Ms/Mrs/Mr.) _____

Last Name _____

First Name _____ **M.I.** _____

Company/Organization _____

Home Address _____

Home City _____

Home State _____ **Zip** _____

Primary Email _____ **Secondary Email** _____

Phone _____ **Cell** _____

Are you a NYMHCA member? _____ **Membership Number** _____

Membership Type _____ (professional/student/retired/associate)

Work Setting _____

Areas of Specialization _____

Date(s) of Workshop _____ **Maximum # of Registrants** _____

Presenter _____ **Location** _____

Mail this form and your check or credit card information for \$275 (NYMHCA Member) or \$350 (Non-Member) to: NYMHCA, 206 Greenbelt Parkway, Holbrook, New York, 11741

Cancellation Policy: NYMHCA will refund 80% of the workshop fee if we receive your workshop cancellation and refund request in writing, no less than 2 weeks before the date of the workshop.

Credit Card Information:

Payment Type Check_____ Credit Card_____

Name as it appears on card_____

Credit Card: ___ VISA ___ Mastercard ___ Discover ___ Debit

Card Number_____ CVV Code (on back of card)_____

Expiration Date_____