

SSTAR 2010 Fall Clinical Meeting
Friday, October 8, 2010
The Penn Club of New York

MEETING REGISTRATION FORM

Registration Payment Required - \$150 (\$45 Students)
(Note: there is no reduction in fee if one forgoes the luncheon at The Penn Club)

(Please print or type)

Name: _____

Badge Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (____) _____ **E-Mail:** _____

Luncheon *(Please select one)*

I will have lunch at The Penn Club

I will NOT have lunch at The Penn Club

Please check here and specify if you require a vegetarian meal or if you have requirements for special assistance during the meeting.

Payment Information:

Check (made payable to SSTAR) Check # _____

Master Card Visa AMEX

Credit Card Number: _____

Exp. Date: ___/___/___ Last 3 or 4 Digits on the Back of the Credit Card _____

Amount to Charge: \$ _____ (Students must include verification to receive the discounted rate of \$45).

Signature: _____

The above signature hereby authorizes this transaction.

Please complete this registration form and CE form and mail with your payment to:

SSTAR National Office, Marion Johnson
409 12th Street SW
Washington, DC 20024

Or fax with Credit Card information to: (202) 554-0453

Cancellation Policy: Written cancellations must be received prior to **Friday, September 17, 2010**. A US administrative fee of \$50 will be subtracted, except for Students. No refund will be issued after this date.

CONTINUING EDUCATION CREDIT REGISTRATION

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To be completely registered for the Full Day Workshop, please complete the information below. To receive Continuing Education Credits, each registrant must have paid the workshop fee and the \$50 fee for CME or \$25 fee for all other CE. For questions regarding credits, please contact the SSTAR CE Officer, Dr. Brian Zamboni, at (612) 625-1500 or bzamboni@umphysicians.umn.edu

NAME: _____
(AS IT WILL APPEAR ON CE CERTIFICATE/S)

DEGREE/S: _____
(AS IT WILL APPEAR ON CE CERTIFICATE/S)

ADDRESS: _____

CITY: _____ **STATE** _____ **ZIP** _____

PHONE: (____) _____

E-MAIL: _____

Type of continuing education credits desired:

- Physicians**
- Sex Educators, Counselors & Therapists**
- Psychologists**
- Marriage & Family Therapists**
- Clinical Social Workers**