



The Postpartum Stress Center 10-hr Postgraduate Clinical Training Program

The Postpartum Stress Center
1062 Lancaster Ave, suite 2
Rosemont, PA 19010
Attn: PPD Training
Postpartumstress.com

REGISTRATION APPLICATION

Eligibility: The training is open to masters and doctoral level professionals in the mental health field and to graduate students in accredited programs in mental health.

Contact Information

Name:		Email:	
Street Address:		Apt/Unit/Mailbox #:	
City:		State:	Zip:
Work Phone:	Cell Phone:	Home phone:	
Profession:	Degree:	Yr obtained:	Yrs in field:
<input type="checkbox"/> Grad student: Degree studying:			Expected date of completion:

Date of Training (check one)

<input type="checkbox"/> Fri-Sat September 10-11, 2010	<input type="checkbox"/> Fri-Sat March 4-5, 2011
<input type="checkbox"/> Fri-Sat December 3-4, 2010	<input type="checkbox"/> Fri-Sat June 3-4, 2011
	<input type="checkbox"/> Fri-Sat September 9-10, 2011
	<input type="checkbox"/> Fri-Sat December 2-3, 2011
Friday class 9am – 4pm Saturday class 9am – 1pm	

Registration (check one)

<u>Early Registration MUST be received 2 months prior</u>	Early Registration (Fri/Sat)	Regular Registration (Fri/Sat)
Single Registrant	<input type="checkbox"/> \$900	<input type="checkbox"/> \$950
Group Discount (3 or more colleagues registering 15% each)	<input type="checkbox"/> \$795	<input type="checkbox"/> \$835
Grad Student (verification required)	<input type="checkbox"/> \$750	<input type="checkbox"/> \$775

Registration includes continental breakfast. Lunch on your own Friday. Lunch provided Saturday.

Payment (check one)

<input type="checkbox"/> I am paying with enclosed check Check # _____ Make check payable to: The Postpartum Stress Center	
<input type="checkbox"/> I am faxing registration and will mail check Fax completed registration form to 610-525-3997	
<input type="checkbox"/> I am paying with credit card (circle one)	
Card #: _____	Expiration Date: ____/____/____
Signature: _____	Today's Date: ____/____/____

Cancellation Policy (Please read)

Any changes with registration must be made thirty (30) days in advance of the training date.
 Option # 1: 100% of fee may be transferred to a future training. This credit will expire one (1) year from the date of the original training.
 Option #2: 50% refund for canceled registration with no credit toward future training.

Continuing Education

The PPSC training program is approved by the PA State Boards of Social Workers, Marriage & Family Therapists & Professional Counselors (10 credits)

Please complete the following so we can best customize the training to meet your professional needs.

[Please also send us your C.V. with registration form]

Describe your previous or current experience with PPD related work:

Please tell us what you hope to gain from this experience and how it will be useful for your practice:

What do you consider your greatest professional strength?:

What do you consider your greatest area of vulnerability in your work?:

How did you hear of our training?:

Anything else you would like us to know that would be helpful in the meeting your professional needs?:

Final Checklist

PLEASE INCLUDE A COPY OF YOUR C.V. WITH THIS REGISTRATION FORM

Do you have directions to the PPSC? (available on website postpartumstress.com)

Will you need hotel accommodation information? Please check website for details and email: training@postpartumstress.com

Do you have copies of the books *This Isn't What I Expected*, *The Postpartum Husband*, *What am I thinking?* Please read them prior to class.

Please make sure you have indicated the dates of the training session for which you are registering.

Do you need further clarification or have any questions? Call us 610.525.7527, x3 or email: training@postpartumstress.com

Thank you for your interest in our program and I look forward to working with you.

