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| **Section C: DOMESTIC VIOLENCE OFFENDER TREATMENT PROVIDER TRAINING COURSES**  *Please select which training course option you would like to register for. Class Time 8am-5pm*   |  |  |  | | --- | --- | --- | | **Course Name** | **Date** | **Location** | | **Five Day Certification Course: $495** |  |  | | \_\_\_\_\_ Domestic Violence Treatment Provider Certification Training | April 12th, April 13th, April 14th, April 20th, April 21st | In-Person (3130 Bonita Rd Ste 207) | | **Single Day Education course: $150 for Single Day Training** |  |  | | \_\_\_ Narcissism and DV 101 | April 12, 2024 | In-Person (3130 Bonita Rd Ste 207) | | \_\_\_ Trauma 101 and the Effects of Abuse | April 13, 2024 | In-Person (3130 Bonita Rd Ste 207) | | \_\_\_ The Victim Experience | April 14, 2024 | In-Person (3130 Bonita Rd Ste 207) | | \_\_\_\_ Abuse and Cultural Context | April 20, 2024 | In-Person (3130 Bonita Rd Ste 207) | | \_\_\_\_ Practice, Implementation, & Role of the Therapist/Facilitator | April 21, 2024 | In-Person (3130 Bonita Rd Ste 207) | |

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| **Section A: COURSE INFORMATION** |
| Course Name: Domestic Violence Offender Treatment Provider Training |
| Course Location: 3130 Bonita Road Suite 207, Chula Vista, CA 91910 |
| **Section B: REGISTRANT INFORMATION** |
| \*Last Name: \*First Name: Middle initial: |
| Mailing Address: City: Postal Code: |
| \*Telephone: Work: Cell Phone: Home: |
| Fax: \*Email: |
| Professional Title: |
| Company/ Organization: |

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| **Section D: SIGNATURES** |
| Applicant: \_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Signature  ***\*Credit card authorization form (on backside) must be completed & submitted with registration form to complete registration & reserve your spot in training*** |
| **Please email or fax the completed registration from to the Safe Solutions Office at least 2 days prior to the course** |
| Email: [Admin@vmrtherapy.com](mailto:Admin@vmrtherapy.com), [DRV@vrmtherapy.com](mailto:DRV@vrmtherapy.com), or Fax: (619) 500-5834  Staff Use Only  Registration form complete (staff to check): Yes No Date:\_\_\_\_\_\_\_ Checked by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Payment completed: Yes No Email Receipt Confirmation: Yes No Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Comments; |

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**REGISTRATION FORM**

**Domestic Violence Offender Counselor Certification Training**

**April 12th,13th,14th, April 20th, 21st 2024 Time: 8am – 5pm PST**

**Credit Card Authorization Form**

Please compete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancellation.

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| **Credit Card Information** |
| Card Type: Mastercard Visa Discover  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cardholder Name (as shown on card): |
| Card Number: CVV: |
| Expiration date (mm/yy): |
| Cardholder Zip Code (from credit card billing address): |

VMR Therapy Inc.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to charge my credit card above for the agreed upon purchase. I understand that my information will be saved to file for future transactions on my account.

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Customer Signature Date