



Conference of the Americas:
A Challenging Treatment in Challenging Times: How Relational Self Psychology Helps
Saturday, October 24, 2020

CONFERENCE REGISTRATION

Please use one form per registration.

Last Name: _____ First Name: _____ Degree(s): _____

Address: _____

City: _____ State: _____ ZIP/ Postal Code: _____ Country: _____

Phone Number: () _____ E-Mail: _____

Profession (please check): Social Worker: _____ Psychologist: _____ Physician: _____ Other: _____

State/Professional License No.: _____ (for CE Certificate)

REGISTRATION FEES:

Please indicate registration type by checking the box:

IAPSP Members:		✓
Professional	\$75	
Student / Candidate / Early Career Professional*	\$35	
Nonmembers:		
Professional	\$95	
Student / Candidate / Early Career Professional*	\$45	
Fees based on Geographic Area:**		
South America (excluding Argentina)	\$25	
Argentina	\$15	
Central America / Mexico	\$25	
South Africa	\$25	

*Early Career Professionals are in practice for less than 5 years and have completed graduate school in 2015 or later.

** Fees based on Geographic areas are for any registrant from the countries / areas listed, regardless of membership or professional status.

Simultaneous translation (English-Spanish) and (English-French) will be available for the clinical presentation, discussion and question / answer portions of the program.

All registrants will be assigned post presentation discussion groups. There will be Spanish and French language groups available. Please select here to be added to the Spanish or French group.

Spanish _____ French _____

CANCELLATION/REFUND POLICY

Refunds will be given less a \$15.00 administration fee if request is received in writing via email, fax or mail by October 10th, 2020. Cancellations received after October 10th cannot be accepted.

PAYMENT INFORMATION

Payment must accompany registration form. Fees in U.S. dollars.

TOTAL AMOUNT DUE \$ _____

☐ Check Enclosed. Payable to: **IAPSP**
(A \$25.00 U.S. fee will be assessed for returned checks)

☐ Credit Card: ☐ VISA ☐ MasterCard ☐ AMEX

Card #: _____

Exp. Date: _____ 3- or 4-Digit Security Code#: _____

Signature: _____

Credit Card Billing Statement Address: _____

IF PAYING BY CHECK, MAIL REGISTRATION FORM AND PAYMENT TO

IAPSP

10685-B Hazelhurst Dr. #26072 Houston, TX 77043 USA

Phone: (888) 699-9299

Email: admin@iapsp.org **Web:** www.iapsp.org

WE CAN ONLY ACCEPT CHECKS FROM THE UNITED STATES IN USD.