



Cognitive Therapy Certificate Programs
Registration Form

College of Health Sciences

Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone () _____ Fax () _____

Fax _____ Email _____

Course fee: CD-ROM format \$199 + \$5.00 shipping
Videotape format \$224 + \$5.00 shipping

Check program choice:

- Cognitive Therapy: Interventions for Healthcare Providers—CD-ROM
Cognitive Therapy: Interventions for Healthcare Providers—Videotape
Cognitive Therapy: Advanced Applications for Healthcare Providers—CD-ROM
Cognitive Therapy: Advanced Applications for Healthcare Providers—Videotape

(Note: Basic Level must be completed prior to beginning Advanced Level.)

Enclosed is a check payable to the University of Delaware in the amount of \$ _____

Charge my credit card: VISA MasterCard Discover AmEx (circle one) \$ _____

Card # _____ Expiration Date _____

Cardholder Name _____

Signature _____



Educational Power
to Span the Globe

Mail completed form with payment to:

Division of Special Programs
Cognitive Therapy Registration
College of Health Sciences
University of Delaware
Newark, DE 19716

or

Fax: (302) 831-4550