

**Specialized Training in Refugee Mental Health
Registration Form**

Name: _____

Agency/ Practice Address: _____

Email: _____

License # _____ Profession _____ Licensure level _____

Please check each training day that you plan to attend

_____ **The Mental Health Needs of Refugee Communities in Minneapolis/St. Paul**
Friday, October 8, 2010 8:30-4:30

_____ **Refugee Cross-Cultural Mental Health Assessments**
Friday, December 3, 2010 8:30-4:30

_____ **Working with Interpreters**
Friday January 21, 2011, 8:30-4:30

_____ **Refugee Mental Health and Evidence Based Treatments**
Friday, March 2011 8:30- 4:30

_____ **Cross-cultural Ethics and Evaluation**
Friday, April 29, 2011 8:30-4:30

Please enclose a check addressed to: Minnesota Council of Churches in the amount of:

_____ x \$125 = _____
(# of sessions attending) Total (Make check out for this amount)

_____ I am interested in being part of the Refugee Services Mental Health Professional referral pool. Attached is a copy of my license, malpractice insurance, location of my practice and a list of insurance panels with whom I am contracted. Please contact Sue Johnston, 612-230-3213 for more information on scholarship assistance.

Return this form to
Sue Johnston, LICSW
Refugee Services, Minnesota Council of Churches
122 W Franklin Ave, Ste 100, Minneapolis, MN 55404

Questions? Call Sue at 612-230-3213