



Valeo Behavioral Health Care  
Continuing Education ~ Workshop/Seminar

Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_

Credentials: \_\_\_\_\_ License Number: \_\_\_\_\_

Title of Workshop/Seminar attending: \_\_\_\_\_

Date/Time of Workshop/Seminar: \_\_\_\_\_

I will use my CE funds       I have attached payment      Fee for seminar \_\_\_\_\_

RU \_\_\_\_\_ - 53070-00

Signature of Employee: \_\_\_\_\_

Date

Signature of Supervisor: \_\_\_\_\_

Date

**Forward to Doti McDonald at 330 SW Oakley, Topeka, KS 66606; fax number (785)233-0085**

**External Participants only**

Name: \_\_\_\_\_

Credentials: \_\_\_\_\_ License Number: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ e-mail: \_\_\_\_\_

Payment is enclosed

I will pay by Credit Card (call Doti at (785)233-1730 ext. 3346)

**There will be no refund if cancelation occurs within 5 business days of workshop.**