VMR THERAPY INC.

REGISTRATION FORM
Domestic Violence Offender Counselor Certification Training
April 4th, 5th, 6th 8AM – 5PM April 12th & 13th 8AM – 5PM

Section A: COURSE INFORMATION

Course Name: **Domestic Violence Offender Treatment Provider Training April 2025**

Course Location: 3130 Bonita Road Suite 207, Chula Vista, CA 91910

Section B: ATTENDEE INFORMATION

*Last Name:	*First Name:	Middle initial:
Mailing Address:	City:	Postal Code:
Telephone: Work:	Cell Phone:	Home:
Fax:	*Email:	
Professional Title:		
Company/ Organization:		

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(s)	Location
Full-Five Day Certification Course: $495		
_____ Domestic Violence Treatment Provider Certification Training	April 4th , April 5th, April 6th, April 12th, April 13th.	In-Person (3130 Bonita Rd Ste 207)
Single-Day Education Course: $250 for Single Day Training		
____Day 1: DV 101 and DV Psychology 101	April 4, 2025	In-Person (3130 Bonita Rd Ste 207)
____Day 2: Psychological & Physiological DV Trauma Responses	April 5, 2025	In-Person (3130 Bonita Rd Ste 207)
____Day 3: Abuser Typologies, Psychogenesis & Psychodynamics of Narcissism & Borderline Personalities	April 6, 2025	In-Person (3130 Bonita Rd Ste 207)
____Day 4: Transference & Countertransference, Self of DV Therapist & Self-Care, Testimonials	April 12, 2025	In-Person (3130 Bonita Rd Ste 207)
____Day 5: Coordinated Community Care, Risk, Safety & Danger Assessments, DVRP Implementation	April 13, 2025	In-Person (3130 Bonita Rd Ste 207)

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 form to the VMR Therapy admin@vmrtherapy.com

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;

Credit Card Authorization Form

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

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

I, _____authorize VMR Therapy Inc. 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.

_____ _____

Attendee Signature Date