‘INTRODUCTION TO CBT’ COURSES 2018-19 APPLICATION FORM

Please tick box(es) for course you want (NB You can book workshops only within one Series)

<table>
<thead>
<tr>
<th></th>
<th>Price</th>
<th>SERIES 1</th>
<th>SERIES 2</th>
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<tbody>
<tr>
<td>Whole course: all 4 x 2-day workshops</td>
<td>£990</td>
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<td>Or individual 2-day workshops as below (but see notes re taking Parts in the correct order):</td>
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<td>Part 1: Assessment and Formulation</td>
<td>£270</td>
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<td>Part 2: Basic Therapeutic Skills</td>
<td>£270</td>
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<td>Part 3: Working with Depression</td>
<td>£270</td>
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<tr>
<td>Part 4: Working with Panic; Health Anxiety; OCD; Social Anxiety</td>
<td>£270</td>
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For Part 4 only, you can book individual days:

| Part 4: Day 1 only - Panic; Health Anxiety                        | £135  |          |          |          |
| Part 4: Day 2 only - OCD; Social Anxiety                         | £135  |          |          |          |

Please complete the following in BLOCK CAPITALS

Name: __________________________________________________________

Profession: ______________________________________________________

Address: _________________________________________________________

_________________________________________________________________

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_________________________________________________________________

Postcode: _____________________________

Tel no.: ______________________________ Fax no.: _____________________

E-mail: _________________________________________________________

Please enclose a cheque made payable to Oxford Health NHS Foundation Trust, or provide invoicing details below and attach a copy of the official purchase order to this application form before sending to OCTC. Ensure supplier details on PO read: Oxford Health NHS Foundation Trust, Accounts Payable, Corporate Services, LMHC, Sandford Road, Littlemore, Oxford OX4 4XN but send to OCTC address at foot of this application form.

We cannot secure your place without an official purchase order and the name of the person authorising this invoice.

Authorising person’s name: ______________________________________

Full name of Trust/organisation: ________________________________

Invoice address: _______________________________________________

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_________________________________________________________________

Postcode: _____________________________

Tel no.: ______________________________ Fax no.: _____________________

E-mail: _________________________________________________________

Please return this form to: OCTC, Warneford Hospital, OXFORD, OX3 7JX
Tel 01865 902801; e-mail octc@oxfordhealth.nhs.uk