**CONTACT.jpg**

|  |  |  |
| --- | --- | --- |
| **Organization** |  | **Name** |
| **Address** |  | **Title** |
| **City** | **State** | **Zip Code** |
| **Phone □ Home □ Office □ Cell** |  | **E-mail** |

**MEMBERSHIP INFO.jpg**

|  |  |  |
| --- | --- | --- |
| **DATE** | **CONFERENCE TITLE** | **COST** |
| **3/15/13** | **Asian Coalition Advocacy and Leadership Training** | **FREE** |
| **3/15/13** | **County Employee (only)** | **$5.00** |
| **SPECIAL ACCOMODATION(S):**  ***Check All That Apply:***  □ Language Translation (specify language): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Sign Language (deaf/hearing impaired): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Dietary Needs (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Total Due** | **$** |

**County Employees Please Complete: ($5 Fee)**

EMPLOYEE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYEE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUPERVISOR’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUPERVISOR’S SIGNATURE:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Make Checks Payable to Department of Mental Health (DMH)

**Please Fax your Completed Registration Form to (213) 687-7159**

**OR e-mail to** [**gnang@cnmsocal.org**](mailto:gnang@cnmsocal.org)

**OR Mail Completed Form to:**

**Attn: Gigi Nang**

**Center for Nonprofit Management**

**1000 N. Alameda Street, Suite 250, Los Angeles, CA 90012**