

# REGISTRATION FORM

**Team Up: Building Partnerships for Children with Autism in Arkansas**  
**April 16-17, 2010 - Arkansas Children's Hospital, Little Rock, AR**

Pre-Registration Fees	Received on or before <u>March 26, 2010</u>	Received March 27, 2010 - <u>April 9, 2010</u>
<input type="checkbox"/> <b>Physicians and Scientists</b> (M.D., D.O., Ph.D.)	\$ 60	\$ 75
<input type="checkbox"/> <b>Allied Health Professionals</b> (RN, APN, SLP, OT, PT, SW, Nutritionist)	\$ 40	\$ 50
<input type="checkbox"/> <b>Educators</b> (Teachers or Administrators, Child Health Advocates)	\$ 40	\$ 50
<input type="checkbox"/> <b>Parents or Family Member of child with Autism</b>	\$ 20	\$ 20

**PRE-REGISTRATION DEADLINE - APRIL 9, 2010**

**TO REGISTER - CHOOSE AN OPTION**

<p><b>Online:</b> Go to <a href="http://www.archildrens.org">www.archildrens.org</a>, click on Conferences/Courses and select the link for "TEAM UP: Building Partnerships for Children with Autism in Arkansas"</p>	<p><b>Mail a check</b> payable to <b>Arkansas Children's Hospital</b> 6 Children's Way – Slot 682 Little Rock, AR 72202-3591</p>
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**Title:**  M.D.  D.O.  Ph.D.  Allied Health Professional  Educator  Parent/Family

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Office Practice Name:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City/State/Zip Code:** \_\_\_\_\_

**Office Telephone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_ **SS#: Last 4 digits XXX-XX-** \_\_\_\_\_

**CONCURRENT SESSIONS: Friday, April 16, 2010**  
**Please indicate the Session you would like to attend (1:00 – 2:00 p.m.)**  
 Session A: Developing Play Skills in Preschool Children with Autism Spectrum Disorders  Session B: Nutrition Issues  
**Please indicate the Session you would like to attend (2:00 – 3:00 p.m.)**  
 Session A: Current and Future Directions: Autism in Arkansas Schools  Session B: Assistive Technology Options  
**Please indicate the Session you would like to attend 3:15 – 4:15 p.m.)**  
 Session A: IEPs: What Every Educator and Parent Should Know  Session B: Navigating Services in Arkansas  
**Will you attend the Special Interest Group Session: Legislative Update, 5:30 p.m.**  Yes  No

Physician  Allied Health Professional  Educator  Parent/Family **Total Amount Due: \$** \_\_\_\_\_

**Payment Method:**  Check (Payable to **Arkansas Children's Hospital**)  
 Visa  MasterCard  Discover  American Express

**Card Number:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_ **Verification Code:** \_\_\_\_\_ **Amount to charge:** \_\_\_\_\_

**Name on card:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Cancellation and Refunds:** To receive a refund, cancellations are required in writing at least 60 days prior to the conference. Please send (by mail [Attention: Jackie Jagers, Continuing Medical Education, Arkansas Children's Hospital, 6 Children's Way - Slot 682, Little Rock, AR 72202-3591], by fax [501/364-3892], or by e-mail [jagersjf@archildrens.org]). A handling fee of \$20 will be deducted for all cancellations after 60 days prior to the conference. Cancellations received after **March 26, 2010** are non-refundable.