RIHAP Grand Rounds
"Access to Language"
Friday, May 13, 2016

REGISTRATION FORM

Please PRINT clearly the following information:

ATTENDEE INFORMATION:

Name: _____

Employer: _____

Mailing Address: _____

City: _____ State: _____ Zip _____

Daytime Phone: (_____) _____

E-mail: **(Required):** _____

Registration confirmations will be sent via email, May 6, 2016 to the email above.

I will be requesting CEU's? ☐ no ☐ yes

☐ ASHA Account/Membership #_____

☐ AAA Account/Membership # _____

SPECIAL ACCOMMODATIONS NEEDED:

☐ ASL Interpreter ☐ Assisted Listening Device

- CART is provided at all plenaries.
- Front row seating is reserved.

REGISTRATION FEES:

Professional Speech Pathologists and Audiologists requiring CEU's:
$15
All other attendees: **FREE**

Today's Date: _____ Total Amt. Due: $ _____

Registration fee payable by check or money order to:

Women & Infants Hospital

Mail payment AND completed registration form to:

Women & Infants Hospital
Attn: RIHAP
134 Thurbers Avenue Suite 215
Street, Providence, RI 02905