AUTISM SOCIETY
OF NEWFOUNDLAND AND LABRADOR
Shamrock Farm · A Place to Grow.

THE ELAINE DOBBIN CENRE FOR AUTISM
Registration Form

PERSONAL INFORMATION:

Name: ____________________ Date of Birth: ____________ (D/M/Y) Male/Female

Primary Address:
Name of primary caregiver (s):
____
____
Street: ____________________
Unit/Apt. #: ____________________
City/Town: ____________________
Postal Code: ____________________
Home Phone #: ____________________
Business Phone #: ____________________
Business Phone #: ____________________
Cell Phone #: ____________________
E-Mail: ____________________
First Language: ____________________
Other Languages Spoken: ____________
____

Marital Status:
Married/Divorced/Single Parent/Common Law/Legal Guardian
____

Secondary Address (if relevant):
Name: ____________________
Street: ____________________
Unit/Apt. #: ____________________
City/Town: ____________________
Postal Code: ____________________
Phone #: ( ) ____________________
E-Mail: ____________________
Siblings: ____________________
____
____

MEDICAL INFORMATION:

Diagnosis: ____________________
Diagnosis Given By: ____________ Position: ____________________
Name of Organization: ____________________
Street: ____________________ City/Town: ____________________
Postal Code: ____________________ Phone #: ( ) ____________________
Fax #: ( ) ____________________

Please complete the attached form, Request for Documentation of Diagnosis of ASD.
(Please note that documented diagnosis are required only for individuals born after January, 1990.)

INDIVIDUAL SUPPORT SERVICES PLAN (ISSP) or GENERAL SERVICES PLAN (GSP)

Is one currently in place for the applicant?
YES: _____ NO: _____
Team Manager: ____________________ Position: ____________________________
School: ____________________________ Street: ______________________________
City/Town: ________________________ Phone #: (   ) ________________________
Postal Code: _______________________ Fax #: (   ) ___________________________

INFORMATION OF PERSON MAKING REFERRAL: (if not primary caregiver)

Referral made by: Family ___ Hospital ___ Agency ___ School ___ Other ___________
Name: ___________________________ Position: ____________________________
Name of Organization: ____
Street: ___________________________ City/Town: __________________________
Postal Code: ______________________ Phone #: (   ) ________________________
Fax #: (   ) ___________________________
How did you hear about Shamrock Farm Centre for Autism? __________________
____

REGISTRATION FEES:

ASNL Member $10.00: ____________ **Non-Member $25.00**: ________________

Mail-in payment will be accepted by cheque, VISA, or MasterCard.
Cash will be accepted if application submitted in person.
Cheques are made payable to the Autism Society of Newfoundland and Labrador.
If paying by credit card, please complete the following:
Type of Card: **VISA** __ **MasterCard** __
Card Number: _____________________________________
Expiration Date: ________
Name appearing on card (please print): ______________________________

Signature Authorizing Transaction: _________________________________