

Join ASRC Email List

Please fill out the form completely. All information given to ASRC will be held as confidential and not shared with anyone. Providing us with complete information will ensure that you receive all mailings relevant to you and your family, and/or your practice or service.

Personal Information

First Name: _____ Last Name: _____

Organization Name: _____ (if applicable)

Address: _____ Apt. # _____ P.O. Box _____ Suite/Floor _____

City: _____ State: _____ County: _____ Zip code: _____

Day time phone (____) _____ Evening phone w/ area code (____) _____

Email address: _____ (The MAJORITY of notices and updates from our Center will be sent to you via email. Failure to give us your email may prevent you from receiving these important notices.)

For Individual/Family

I am a(n) (check only one):

_____ **Parent/Family member**

If parent/family member of an ASD child, please provide the following:

Birthdate (with year) of child ____/____/____ Male _____ Female _____

ASD Diagnosis Asperger's syndrome Classic Autism High-Functioning Autism
 Non-verbal Learning Disability PDD-NOS Unknown

Dual Diagnosis (if any) _____

** Please note: For more than one diagnosed child, please fill out information on page 2 with child(ren)'s information.

_____ **Adult with an autism spectrum disorder**

My birthdate (with year) ____/____/____ Male _____ Female _____

ASD Diagnosis _____ Dual Diagnosis (if any) _____

For Private Practitioner

_____ **Private practitioner**

Please specify: psychologist, OT, camp, etc. _____

For Community Provider/Educator

I am a(n) (check only one):

_____ **Educator/Birth to Three**

Please specify: special ed. teacher, speech/language, OT, etc. _____

Please indicate district or private school _____ grade _____

_____ **Community Provider for service agency (i.e. Birth to Three, DMR, BRS)**

Please Specify: job coach, respite, case manager, etc. _____

Agency _____

Support Groups

_____ I would like information about support groups (ASRC will call you with local information).

Contributions

_____ I would like to make a tax deductible contribution in the amount of: \$ _____

Please note: The CT Autism Spectrum Resource Center is a 501(c)(3) organization.

Continued →

For Additional Diagnosed Children from page 1, please fill out the information below:

1. Birthdate with year of child ____ / ____ / ____ Male _____ Female _____

ASD Diagnosis _____ Dual Diagnosis (if any) _____

2. Birthdate with year of child ____ / ____ / ____ Male _____ Female _____

ASD Diagnosis _____ Dual Diagnosis (if any) _____

You can also register online at ct-asrc.org



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Email: ct-asrc@sbcglobal.net