i-PAD APPLICATION (2 Pages)

Submissions Accepted Annually from OCT 1st to NOV 1st

Name of child with autism: _____ Age: _____

Parents Names:

_____

Address:

_____

_____

_____

Home Number: _____

Cell Number: _____

Email address: _____

Please list at least 3 non -families members that can verify that you are in need of this program. Also, provide contact info for your Primary Care Physician plus the Speech Therapist or Other Specialist recommending that an iPad would be beneficial.

Note that by submitting this application you are giving PAF permission to contact the following to verify information you've provided.

Name: _____ Relationship: _____

Phone Number: _____ Email:_____

Name: _____ Relationship: _____

Phone Number: _____ Email:_____

Name: _____ Relationship: _____

Phone Number: _____ Email:_____

PARKER AUTISM FOUNDATION

Primary Doctor: _____Phone Number_____

Speech Therapist or Other Specialist recommending the use of an i-PAD.

Name: _____ Phone Number: _____

I understand that I will be required to complete 4 hours of volunteer hours . Volunteer hours are due one year from the date of this application. It is your responsibilities to contact us for volunteer opportunities.

Please provide the following information to complete this application.

WE most have a current copy of you tax return
Proof of diagnoses for your child that has autism.
Proof of address- electric bill in your name, etc.
Letter explaining how this program will affect your family.

I swear that everything I have stated in this application is true to my best abilities.

Signature: _____Date: _____

Signature: _____ Date: _____