REGISTER ONLINE at https://www.sralab.org/academy or complete the form below and return with payment. Questions? Contact Academy@sralab.org

Course Title: _____

Course Date: _____

Other Registration Information (ie: live or on-demand learner, workshop selection, etc.)

_____

Please TYPE or PRINT your name and professional initials (MD, OT, PT, RN, etc.) as you would like them to appear on your continuing education certificate.

First Name _____ Last Name _____

Home Phone (_____) _____ Prof. Initials _____

Home Address _____

City _____ State _____ Zip _____

Organization/Facility _____

Work Address _____

City _____ State _____ Zip _____

Work Phone (_____) _____ Fax (_____) _____

Position _____

E-mail (required) _____

I would like to receive information by e-mail from the academy: Yes No

Please note that registration will not be processed without full payment.

Method of Payment: Check enclosed (Payable to: Shirley Ryan AbilityLab