

CONTACT INFORMATION

First name: _____ Last name: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

Home phone: _____ Work phone: _____

Best hours to be reached: _____ Today's date: _____

LEVEL OF CERTIFICATION
(please circle the appropriate level)

RESPITE: I II III *CPR:* Adult Child Infant None *MANDT:* YES NO

MEDICAL: EMT RN CNA 1ST AID *LIFESAVING:* YES NO

OTHER RELEVANT TRAININGS / EXPERIENCE / BACKGROUND: _____

(use back if necessary)

PLEASE CHECK THE APPROPRIATE LINES BELOW

___ I have provided respite care at the ASM Family Retreat before. What year? ___

I will provide respite care at the ASM Family Retreat this year ___ Yes ___ No ___ Not Sure

I will arrive ___ Friday night ___ Saturday morning

I will be staying overnight on campus ___ Friday night ___ Saturday night ___ Not At All

I prefer to provide care for ___ Children with autism ___ Siblings ___ Doesn't matter

___ I would like to make the following comments, suggestions, request, etc.: _____

___ I am interested in providing respite care but can not commit at this time. I will contact ASM by June 30th to confirm whether I will or will not be able to provide respite care.

___ I can not provide respite care at the ASM Family Retreat this year , but I am interested in future oppoortunities.