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| Name: | Initials: |
| Degrees: | Year Obtained: |
| Where Obtained: | |
| Place of Work: | |
| Work Address: | |
| City, State, Zip: | |
| Work Phone: | Fax: |
| Other number to post: | Email: |
| Names of associates in your practice, if applicable: | |
| Age range which you serve: | Hourly fee: |
| Are you a Medicaid provider? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Insurance companies for which you are a provider? | |
| If parents lack insurance, do you have a reduced fee? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If you answer yes to the above questions, what is the reduced fee? | |
| Please describe the autism spectrum-related treatment methods which you provide (i.e., ABA, RDI, PECS, DIR, Pivotal Response Training, etc.): | |
| Number of years of experience working with children on the autism spectrum: | |
| Other information which you would like to include: | |
| Services provided: | |
| <input type="checkbox"/> Early Identification/Referral | <input type="checkbox"/> Diagnostic |
| <input type="checkbox"/> Treatment | <input type="checkbox"/> Social Skills Groups (ages, population) |
| <input type="checkbox"/> Parent Support/Advocacy | <input type="checkbox"/> School Services (describe) |
| <input type="checkbox"/> Consultation to Agencies/Schools (describe) | <input type="checkbox"/> Other (describe) |
| I, _____, authorize the Oklahoma Autism Network to post my information as a professional resource on the Oklahoma Autism Network website. (www.okautism.org) | |
| Signature: | |