

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. ( <a href="http://www.okautism.org">www.okautism.org</a> )			
Signature:			