



Professional Course Registration

Thank you for your interest in our Program!

Please PRINT CLEARLY and complete all sections of this form.

Today's Date: _____

Name: _____ Title/Profession: _____

Name of Employer: _____

Address: _____

City: _____ State: _____ Zip: _____ County(ies) You Serve: _____

Telephone: () _____ Email : _____

Do you require CEUs? _____ If yes, from which association? (circle) NASW LPCA

How did you learn about this program? _____

Describe the children with whom you work: _____

Do you currently work with children who have special needs? _____ If yes, what specific conditions? _____

In your current position, do you make decisions regarding child placement? _____

When you need information about pediatric health conditions and home care needs for the children you work with, where/how do you obtain it? _____

By signing below, I confirm that I wish to attend *Family for Keeps™* Professional Course, a Dream House for Medically Fragile Children Program. The course fee is \$275 (payable to Dream House), due at the time of registration.

I understand that classes begin promptly and by arriving more than 20 minutes past class time may result in a missed class.

I understand that the information, provided by the Dream House for Medically Fragile Children, Inc. *Family for Keeps™* Program – Education and Skills Training, is basic. The physician who oversees the care of the child(ren) is the authority. The physician's advice and directions will be followed when providing care for any child.

Participant Signature

Date

Please note: You will be asked to silence your cell phone before entering the classroom. Should you need to answer a call, we ask that you step out of the room.

Please mail this one (1) page application, along with payment to:

Dream House for Medically Fragile Children, Inc.
Attn: Family for Keeps™ Coordinator
P.O. Box 1562
Snellville, GA 30078-1562

Phone: 770-717-7410
Fax: 770-923-0659
eMail: info@dreamhouseforkids.org
Web: www.dreamhouseforkids.org

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