

## **Professional Member Information Form:**

Note: This transmission is intended only for the use of the person or office to whom it is addressed and may contain confidential information that is privileged, confidential or protected by law.

Your Name : \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Home Phone: \_\_\_\_\_

email: \_\_\_\_\_

I am a Professional working with children who are blind or visually impaired: Yes \_\_\_ No \_\_\_

Place of Employment: \_\_\_\_\_

I would like to be a part of VAAPVI's statewide listserv for parents and professionals raising/working with children who have visual impairments? Yes \_\_\_ No \_\_\_

Check what kind of professional:

O&M \_\_\_ TVI \_\_\_ OT \_\_\_ PT \_\_\_ ST \_\_\_ Physician \_\_\_ Teacher \_\_\_ Other \_\_\_\_\_

Do you or your office offer services to children? Yes \_\_\_ No \_\_\_

If yes, please specify. \_\_\_\_\_

Would you be interested in participating in workshops? Yes \_\_\_ No \_\_\_ Maybe \_\_\_

Do you know of an upcoming event, clinic, or drive? Yes \_\_\_ No \_\_\_

If yes, please specify. \_\_\_\_\_

Would you consider using our website and newsletter to advertise your services? Yes \_\_\_

No \_\_\_

To help us develop and plan our future programs Please share with us what you would like to see offered in the community. Let us know what kind of information, education or skill building that could be a benefit to professionals or the families and children you are working with.

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