



Dear participant,

Please find attached the registration form for:

Son-Rise Program Start-Up® Wednesday 8 May to Sunday 12 May 2019 Hôtel Mercure Paris 19 Philharmonie La Villette 216 Avenue Jean Jaures 75019, Paris, France

To register, please fill out this form and return it signed and dated with your payment details as soon as possible to ensure your place, and by 24 April 2019 at the latest, either by email to <u>OptimInscriptions@gmail.com</u> or by mail to :

Optim'Autisme Registrations SRP Start-Up 40, rue Lucien Sampaix 75010 Paris, France

We accept the following payment methods:

- Credit card (secure payment): via <u>HelloAsso Tickets</u> in one or multiple instalments;
- Check (French check books only): please send up to 4 checks, made out to Optim'Autisme (post-dated checks will not be accepted), with the dates you would like them to be banked noted on the back of each check, with your registration form, to the above address;
- Bank transfer: see below for our bank details. Please send us a copy of the bank transfer, showing your full name and "SRSU 2019", with your registration form.

Association Optim'Autisme 40 rue Lucien Sampaix, 75010 Paris					
Branch address:	Crédit Agricole, Bayonne St Esprit (40024)				
Bank :	16906				
Guichet :	40024				
Act Number :	87013243679				
Clé :	22				
IBAN : BIC :	FR76 1690 6400 2487 0132 4367 922 AGRIFRPP869				

With energy, excitement and enthusiasm,

The Optim'Autisme team

Optim'Autisme Association loi 1901 40, rue Lucien Sampaix - 75010 Paris – France 01 42 05 92 64 - 06 59 30 15 58 www.optimautisme.com <u>optimautisme@gmail.com</u> RNA: W751234689- SIRET: 824 252 027 00019



Son-Rise Program® Start-Up

8-12 May 2019



Hôtel Mercure Paris 19 Philharmonie La Villette 216 Avenue Jean Jaures, 75019, Paris, France

Registration form

Name:	 Title	First na	me	Last name						
Address:										
	Postco	de	City, State, Coun	try						
Home ph	none:			Mobile:						
E-mail:										
Billing details: (if different)		Billing name								
			Billing address	Billing address						
			Postcode	City, State, Country						
How did	you lea	n about the S	Son-Rise Program	?						
(participa Have you "Autis "Autis "Happ	ant man u read th sm Brea stic Logi piness is	ual, handout ne following b kthrough" by stics" by Kate a Choice" by	s, etc.) books, or will you Raun K. Kaufman	eil Kaufman	 French art-Up? YES YES YES YES YES 	 English NO NO NO NO NO NO NO 				
"Son-	Rise: Th	e Miracle Cor	ntinues" by Barry	"Bears" Neil Kaufman	T YES	NO				
Your child *: .		First name		Last name		girl 🗖 boy				
		Date of birth		Diagnosis						
Relationship:				please specify nal (please specify						
Informat	tion on y	your child's la	anguage:							
Which of	Sounds Simple Simple	- 50 single w phrases (2-3 sentences (n	vords (or has no w word combinatio oun + verb, eg. "t	e box only) My child uses : vords) ns, eg. "blue ball", "want sing" hrow the ball", "push car dow prrect, eg. "Put the books on tl	n slide", "the man	fell down")				

- like that game")
- Combined complex sentences (3 or more sentences in succession)



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Second child	(if applicable)
Vous shild *	

Your child	*.	🗍 girl 🗍 boy							
	First name	Last name							
	Date of birth	Diagnosis							
Relationsh to child	ip: 🗖 Parent 🗖 Volunteer	 Family (please specify							
Informatio	on on your child's langu	uage:							
Which of t	he following best appli	es? (Check one box only) My child uses :							
	ounds - 50 single word	s (or has no words)							
	imple phrases (2-3 wor	rd combinations, eg. "blue ball", "want sing", "book on shelf")							
	imple sentences (noun	ple sentences (noun + verb, eg. "throw the ball", "push car down slide", "the man fell down")							
	Complex sentences (gra ke that game")	plex sentences (grammatically correct, eg. "Put the books on the shelf so we can play dominos - I hat game")							
	Combined complex sent	ined complex sentences (3 or more sentences in succession)							
* or a child	you work with								
Third child	(if applicable)								
Your child	*. First name	girl 🗖 boy							

	Thorna	Last name
	Date of birth	Diagnosis
Relationship:	Parent	□ Family (please specify)
to child	Volunteer	Professional (please specify)

Information on your child's language:

Which of the following best applies? (Check one box only) My child uses :

- Sounds 50 single words (or has no words)
- Simple phrases (2-3 word combinations, eg. "blue ball", "want sing", "book on shelf")
- Simple sentences (noun + verb, eg. "throw the ball", "push car down slide", "the man fell down")
- Complex sentences (grammatically correct, eg. "Put the books on the shelf so we can play dominos I like that game")
- Combined complex sentences (3 or more sentences in succession)

* or a child you work with



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Payment									
Son-Rise Program Sta	rt-Up : 1 250 €¹								
		O SRP volunteer							
Date of request for fi	nancial assistance, if appli	cable							
Single payment€ (cashed immediately)		O HelloAsso	O check	${f O}$ bank transfer 4					
Multiple instalments Deposit € (minimum 250€ to be cashed immediately)		O HelloAsso	O check	O bank transfer⁵					
2 nd Instalment amou	unt€	date to be cashed⁵ ○ HelloAsso							
3 rd Instalment amou	unt€	date to be cashed⁵ ○ HelloAsso							
Balance amou	unt€	date to be cashed⁵ ○ HelloAsso							

(to be cashed two weeks before the Start-Up at the latest, ie, 24 April 2019)

The cost for the Start-Up covers: the training course, simultaneous interpretation between English and French, equipment costs (room, interpretation booths and headsets), the participant manual, morning coffee breaks, and management and organization costs. It does not cover membership of the association **Optim'Autisme**, nor transport, accommodation or food costs while at the Start-Up.

Your registration is confirmed upon reception of the 250 € deposit. In the case of payments by check, checks for the full amount are to be given upon registration and they will be cashed on the dates indicated above.

Please send your first payment with the signed and completed registration form.

In the case of cancellation by the participant: more than 15 days before the first day of the Start-Up, the amount paid will be reimbursed less a 100€ cancellation fee; within 15 days of the first day of the Start-Up, no reimbursement.

In the case of cancellation by the organizers (for lack of registrations or any other reason), participants will be informed as soon as possible, and will be reimbursed the total amount paid.

By signing this document, you give your permission that the personal information written on this form regarding you and your child(ren) be communicated to the Autism Treatment Center of America for the purposes of personalizing the Start-Up and to keep you informed. Your details will not be communicated or sold to any third party.

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Signature

¹ Contact us at OptimInscriptions@gmail.com if you would like to request a different payment instalment plan or financial aid

² Names of people registered together; names of the parents running the Son-Rise Program

³ Memberships as of 1 November 2018 are valid until 31 December 2019

⁴ Please attach a copy of the bank transfer to your registration form

⁵ Checks will be cashed on the 1st and 15th of the month

⁶ Please send a copy of the subsequent bank transfers to <u>OptimInscriptions@gmail.com</u> with your full name and "SRSU 2019"