



# Incorporating Low Vision Rehabilitation into Occupational Therapy

Registration Form September 23, 2011

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Describe your employer and/or the population are you serving:

What low vision techniques are you currently using:

**Mailing Address (check one)** Home  Business

Address line 1: \_\_\_\_\_

Address line 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Check here if same as billing address.

Email: \_\_\_\_\_

**Billing Address (if different than mailing address)**

Address line 1: \_\_\_\_\_

Address line 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

\_\_\_\_\_ Individual Registration: \$125 \_\_\_\_\_ AOTA Member: \$95

NUMBER OF REGISTRATIONS: \_\_\_\_\_ TOTAL DUE: \$ \_\_\_\_\_

*Please complete and attach a registration form for each person attending, even if making one payment*

### 1. TO PAY BY CREDIT CARD:

Visa  Mastercard  American Express

Credit Card No: \_\_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

### 2. TO PAY BY PURCHASE ORDER, BILL TO:

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

Org: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Purchase Order Number: \_\_\_\_\_

*Mail completed form to address below, fax to 212-595-4907, or scan and email to sightcare@jgb.org*

### 3. TO PAY BY MAIL (Check or Money Order):

Make check or money order payable to **The Jewish Guild for the Blind**

Mail with completed form to:

**The Jewish Guild for the Blind / SightCare**  
15 West 65<sup>th</sup> Street  
New York, NY 10023  
Attention: Eileen Morrissey

Questions: Call 800-539-4845 or email [sightcare@jgb.org](mailto:sightcare@jgb.org)