



REGISTRATION FORM (Employee Assistance Programs)

CLIENT INFORMATION

First Name: _____ Last Name: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Phone: _____ Date of Birth: _____

I give Restorative Conversations and the Centre for ADHD permission to contact me by:

Yes No Email: _____

Yes No Telephone: _____ Messages: Yes No

Yes No Text Messages: _____

Yes No **I would like to receive updates on upcoming workshops and groups**

Signature

Date

EMERGENCY CONTACT INFORMATION

First Name: _____ Last Name: _____

Phone: _____ Relationship: _____

