



Site Coordinator Information

Name: _____ Title/Position: _____
 University Name: _____ Department: _____
 Address: _____
 City _____ Province: _____ Postal Code: _____
 Business Telephone: _____ Fax: _____ Email: _____

Second Contact

Name: _____ Telephone: _____ Email: _____

Contact Preference: Mail Email Telephone Fax
 Please check if you DO NOT want to receive marketing materials (catalogues, new product information, and special promotions.)

Program Enrollment(s)

Program Name(s): _____
 Relevant Courses: _____
 Program Annual Enrollment: _____

Program Focus

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Psychology | <input type="checkbox"/> Speech & Language | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> General Education |
| <input type="checkbox"/> Clinical | <input type="checkbox"/> Linguistic Aphasiology | <input type="checkbox"/> Child/Adolescent Psychiatry | <input type="checkbox"/> Classroom Assessment |
| <input type="checkbox"/> Developmental | <input type="checkbox"/> Neurolinguistics | <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Special Education |
| <input type="checkbox"/> Psycho-Educational | <input type="checkbox"/> Developmental Language Disorders | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | |

Program Interests

I would like more information on...

- Research Participation: _____ Product Training: _____
 Continued Personal Development: _____ Product Review: _____

Terms and Conditions of the Program:

Discounts offered as part of this program may not be combined with other offers. By signing this form, you are stipulating that all resources purchased under this program are to be used by students in fulfillment of their training requirements and not for other clinical purposes. These materials will not be loaned or otherwise made available to other practitioners or institutions. All orders submitted for the University Outreach Program discount must be billed and shipped to the applicable University site. All orders under this program must be sent to the attention of the site coordinator named on this form.

By completing this form, you solely consent to our collection and use of your personal information to assess your qualifications and suitability to administer products developed by Pearson Canada Assessment Inc. Your personal information will be kept confidential and treated in accordance with applicable privacy laws and our privacy policy, a copy of which is available on our website at PearsonClinical.ca or by calling 1-866-335-8418.

Pearson Canada Assessment Inc will retain this information for the duration of the customer's involvement with Pearson Canada Assessment Inc. If a customer communicates to Pearson Canada Assessment Inc that he/she is no longer a customer, Pearson Canada Assessment Inc will destroy the customer's information five years from the notification. At any time, a customer can contact Pearson Canada Assessment Inc and inquire about his/her profile and ask that information be removed from the profile.

Signature: _____ Date: _____

OFFICE USE ONLY: Billing Account # _____ Shipping Account # _____ Date validated: _____