

**Clinical Connections Program Request**  
 2225 Lakeside Drive  
 Bannockburn, IL 60015  
 Phone: (847) 234-0688 Fax: (847) 234-0687

Child's Name \_\_\_\_\_ Child's Age \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell/Work Number: \_\_\_\_\_

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

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

I would like to register for the following programs:

(Use corresponding program code; specify sessions per week and hours per session when applicable)

Ex. PPH \_\_\_\_\_ 2 sessions per week, 2 hours per session

1. \_\_\_\_\_ sessions per week, \_\_\_\_\_ hours per session

2. \_\_\_\_\_ sessions per week, \_\_\_\_\_ hours per session

3. \_\_\_\_\_ sessions per week, \_\_\_\_\_ hours per session

4. \_\_\_\_\_ sessions per week, \_\_\_\_\_ hours per session

5. \_\_\_\_\_ sessions per week, \_\_\_\_\_ hours per session

We will do our best to schedule sessions back to back.

When programs do not have specific time information, please indicate ALL DAYS AND TIMES AVAILABLE for therapy. Circle your preferred times in red.

Monday	8	9	10	11	12	1	2	3	4	5	6	7
Tuesday	8	9	10	11	12	1	2	3	4	5	6	7
Wednesday	8	9	10	11	12	1	2	3	4	5	6	7
Thursday	8	9	10	11	12	1	2	3	4	5	6	7
Friday	8	9	10	11	12	1	2	3	4	5	6	
Saturday	8	9	10	11	12	1	2	3	4	5		

Special Instructions:

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Thank you! We will do our best to accommodate you!