Project ECHO:Autism Registration

If you plan to participe in Project ECHO:Autism, please complete this form.
To submit, do one of the following:

1) Click the Submit Form button at the bottom of this form
2) Save form and email to echoautism@peds.uab.edu
3) Print form and fax to 205-638-5089

Health Center

Name of Organization:

Address: City: State: Zip:

County: Phone:

Participant

Name:

Job Title:

Credentials:

Phone:

Email:

Clear Form

Please check the box below to confirm your acknowledgement and consent to participate as a community partner for the Project ECHO: Autism project. I agree to:

Participate collegially in regularly scheduled Project ECHO:Autism conferences by presenting cases, providing comments and asking questions; Provide clinical updates and de-identified outcome data on patients as needed; Keep confidential any patient information provided by other community partners during a conference; Complete periodic survey's to help improve services to clinicians and other partners; Use required software including, but not limited to Zoom and Box; Be solely responsible for the treatment of your patients and understand that all clinical decisions rest with you regardless of recommendations provided by other Project ECHO:Autism participants and; Ensure that your patients are aware of your participation in Project ECHO:Autism and their de-identified information could be shared; Be photographed and recorded during Project ECHO:Autism sessions.

☐ **I agree to the above terms** Submit Form!