Project ECHO:Autism Registration

If you plan to particpe in Project ECHO:Autism, please complete this form and email to echoautism@peds.uab.edu

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Health Center

Name of Organization: ____

Address: ______________________ City: _____________ State: ____ Zip: ________

County: ______________________ Phone: ______________________________

Participant

Name: ____

Job Title: ____

Credentials: ____

Phone: ____

Email: ____

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 WEBEX 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**