Autism Collaborative Center
Service ■ Education ■ Research ■ Community
Eastern Michigan University

Visitor/Observer Information

Name _____ Phone _____

Email _____

Agency Represented (if applicable) _____

EMU Student ○ Yes ○ No If Yes, please indicate your major and current level

_____

Purpose of Visit

Requirement for Course _____ Requirement for Admission _____
Course Name or Number *Program*

Observation of Group/Individual Sessions _____ Number of Hours Required _____

Availability

Mon	Morning ○ 9am – 12pm	Afternoon ○ 1pm-4pm	Evening ○ 5pm – 8pm
Tues	Morning ○ 9am – 12pm	Afternoon ○ 1pm-4pm	Evening ○ 5pm – 8pm
Weds	Morning ○ 9am – 12pm	Afternoon ○ 1pm-4pm	Evening ○ 5pm – 8pm
Thurs	Morning ○ 9am – 12pm	Afternoon ○ 1pm-4pm	Evening ○ 5pm – 8pm
Fri	Morning ○ 9am – 12pm	Afternoon ○ 1pm-4pm	Evening ○ 5pm – 8pm

Date/Time Scheduled for Visit _____

Therapist Name(s) _____

I verify that I have met the above named individual and assisted in addressing the purpose of this visit.

Signature of ACC Representative _____

Signature of Visitor/Observer _____

Date _____

Please note if any further action is needed on the back of this document. Thank you!