

Four Seasons Stuttering Therapy (FSST)

A treatment program for school aged children who stutter

Registration ends Wednesday, July 16, 2014

Program Application

Child's name: _____

Child's date of birth: _____

Previous speech therapy? _____

Contact person: _____

Contact telephone: Daytime: _____ **Cell:** _____

Contact email: _____

Address: _____

Please enroll my child in the FSST program. Enclosed is my enrollment deposit of \$250. I understand this deposit is not refundable unless the speech language evaluation determines my child is not appropriate for this program.

____ **Enclosed is my check made out to *Speech and Hearing Associates***

____ **Please charge my credit card**

Type of card (VISA, Mastercard, American Express, Discover)

Name on card _____

Number _____

Expiration date _____

Please mail this completed form to: Speech and Hearing Associates, 121 South Euclid Avenue, Westfield, NJ 07090 Attn: FSST stuttering program

Or fax to: 908-232-3583 Attn: FSST stuttering program.

**For additional information, or questions, call 908-232-2903 ext. 232
or email: rkratchman@sha1969.com**