



UK Young Autism Project

Svein Eikeseth PhD, Diane Hayward BSc, Catherine Gale BSc

Room 107
20 Mortlake High Street
London SW14 8JN

0208 392 3931
www.ukyap.org

Application Form For Workshop Services

Date of Application:.....

Name of Parents:.....

Name of Child:.....

Date of Birth:..... Chronological Age:.....

Address:.....

.....

Postcode:.....

Telephone Number:.....

Fax:.....

Email:.....

Please make sure the following documents are enclosed:

- Diagnosis
- Certification of absence of medical conditions
- Any other evaluations and assessments of the child
- Recent photograph of child