

**ADMINISTRATOR/TEACHER/RELATED SERVICE  
REGISTRATION FORM**

**22<sup>ND</sup> ANNUAL FAMILY/TEACHER CONFERENCE  
JUNE 19-23, 2009  
EMBASSY SUITES, GREENSBORO**

**SPONSORED BY: THE STATE DEAF-BLIND PROJECT  
NORTH CAROLINA DEPARTMENT OF PUBLIC INSTRUCTION**

**RETURN APPLICATION TO: CHRIS JONES  
N.C. DEPARTMENT OF PUBLIC INSTRUCTION  
EXCEPTIONAL CHILDREN DIVISION  
6356 MAIL SERVICE CENTER  
RALEIGH, NC 27699-6356**

**FAX: 919-807-3243**

**REGISTRATION AND DEPOSIT (\$25 MADE PAYABLE TO DBMANC) MUST BE RETURNED BY MAY 12, 2009**

**(PLEASE PRINT CLEARLY OR TYPE)**

Name: \_\_\_\_\_

Title/Position: \_\_\_\_\_

Home Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: (work) \_\_\_\_\_ (home) \_\_\_\_\_

E-Mail: \_\_\_\_\_ (MUST BE EXACT)

Fax Number: \_\_\_\_\_

School: \_\_\_\_\_

School System: \_\_\_\_\_

Current Area of Certification: \_\_\_\_\_

Name of student/child you currently serve: \_\_\_\_\_

Age of student: \_\_\_\_ Is this child reported on our State Deaf-Blind Census? Yes \_\_\_\_ No \_\_\_\_

Do you require any special considerations (interpreter, etc.)? Specify: \_\_\_\_\_

***PLEASE INITIAL THE FOLLOWING***

- I understand that I may be assigned to a room that I will share with other teachers or staff members  
 I understand that **most** meals and my accommodations will be provided and I will provide my own transportation  
 I understand that I will receive renewal licensure credit

**APPLY EARLY – SPACE IS LIMITED**