BU Aphasia Resource Center: Fall 2026 Registration Request Form

ALL FIELDS REQUIRED

☐ **I am a returning member of the Aphasia Resource Center.**

or

☐ **I am new to the Aphasia Resource Center**

and: ☐ **have included a recent SLP or Neuropsychology report(s) with my registration.**

Name: _____

Address: _____

_____

City State Zip

Phone: _____

Email: _____

Do you need parking?

☐ **Yes**

☐ **No**

If you answered yes, please provide the make, model, and license plate number of your car:

_____

I would like to enroll in _____ (number) groups in total.

*Please **rank** groups of interest in order of preference (#1 being your first choice; 1,2,3)*

	Monday Groups	Wednesday Groups	Thursday Groups
Morning Groups	_____ Conversation (in-person)	_____ Cooking Club (in-person)	_____ Community Connection (in-person)
	_____ Toastmasters (online)	_____ Music Appreciation (online)	_____ Talk of the Town (online)
		_____ Fiction Book Club (online)	
Afternoon Groups	_____ Language Games (in-person)	_____ Canine-Assisted Aphasia Group (in-person)	_____ Wellness Group (in-person)
	_____Story Telling (online)	_____ Movies (online)	_____ Non-fiction Book Club (in-person)

Registration MUST BE RECEIVED BY *Monday August 31st* to receive full consideration.

Please fill out form and return by email to aphasiacenter@bu.edu or call (617) 353 – 0197.

Aphasia Resource Center

The Aphasia Resource Center at Boston University (BU ARC) has as among its primary purposes, the training of students who wish to become speech-language pathologists and audiologists. The BU ARC respects the right of privacy of its clients and will treat all sessions and information regarding its clients as confidential in accordance with applicable law. Each client who is seen at the BU ARC is asked to give consent to the observation and audio and/or video recording of sessions involving the client and to the use of these audio and/or video recordings and other information regarding the client for purposes related to the treatment of the client, operations, and education, including use by students in classroom presentations.

Please be advised that students, faculty and staff at the BU ARC sometime consult with physicians, other professionals, and individuals at agencies, schools, clinics, and other entities for purposes related to the client's treatment. In order to enable the Center and other parties involved with the client's care to consider relevant information, we will share information that we deem appropriate.

I understand that by signing this form, I give my permission for individuals associated with Boston University to:

1. Observe and record sessions either through audio and/or video involving the client.

2. Use of such audio and/or video recordings and other information regarding the client for purposes related to treatment or operations.

3. Use of such audio and/or video recordings and other information regarding the client for purposed related to education, including use in classroom presentations;

4. Share information regarding the client with physicians, other professionals, and individuals at agencies, schools, clinics, and other entities as the Center deems appropriate for purposes of treatment of the client.

Client Name (Print Name)

Signature of Client or Parent/Guardian

Emergency Contact (Print Name)

Phone Number

Send to:
The Boston University Aphasia Resource Center
635 Commonwealth Avenue, 6th Floor
Boston, MA 02215

Date