**Clinic Presenter Information Sheet**

**Name**

(As it should appear in our program)

**Street** **Address**

**City State** **ZIP**

**Phone Number**

**Email Address**

**Clinic/Oral History Title**

**Clinic/Oral History Description**

**A-V Needs:** Digital Projector Slide Projector White Board Other

**Room Set-up:** Theater style Classroom (tables) Other

**Clinic Schedule Preferences** (Please indicate when you would be available to present your clinic(s) by indicating “A” for times you think you would be available and “N” for times you will not be available.

|  |  |  |
| --- | --- | --- |
|  | Wednesday Afternoon 4/4 \_\_\_\_\_ | Wednesday Evening 4/4 \_\_\_\_\_ |
| Thursday Morning 4/5 \_\_\_\_\_ | Thursday Afternoon 4/5 \_\_\_\_\_ | Thursday Evening 4/5 \_\_\_\_\_ |
| Friday Morning 4/6 \_\_\_\_\_ | Friday Afternoon 4/6 \_\_\_\_\_ | Friday Evening 4/6 \_\_\_\_\_ |
| Saturday Morning 4/7 \_\_\_\_\_ | Saturday Afternoon 4/7 \_\_\_\_\_ |  |

Thank you for agreeing to participate in our convention.

Please return this completed form to:

Peter Barnes, 6343 Meadowridge Drive, Santa Rosa, CA 95409

or email to [ER2018clinics@pcrnmra.org](mailto:ER2018clinics@pcrnmra.org)

Phone: (707) 539-6746