

Therapeutic Arts Facility Registration Form

Facility Name: _____

Address: _____

City: _____ County: _____ Telephone Number: _____

Contact Person: _____ Title: _____

Email Address: _____

Type of facility	
Number of beds	
Budget/funding available	W9 needed? Yes <input type="checkbox"/> No <input type="checkbox"/> Invoice needed? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a Piano?	
Do you have a Sound system?	
Type of room available for performance	
Desired time for performance	
Expected audience size	
Do you house patients in need of music therapy?	
Would you like to talk to us about organizing other events in the future?	
Would you be interested in receiving more information about A4AC sponsorship opportunities?	Send to: