SHARON SIGESMUND PIERCE & STEPHEN PIERCE

Center for Autism & Developmental Disabilities
At Touro University Nevada

LEGAL CUSTODY AGREEMENT

Center for Autism and Developmental Disabilities

Patient Name: _____

Patient Date of Birth: _____

I, the undersigned, indicate by my signature below that I have legal custody of my child (named above), and, therefore, the right to seek evaluation and/or treatment for my child. I have been advised by Touro University Nevada Center for Autism and Developmental Disabilities that it is their recommendation that my child's other parent, if applicable, be informed of my decision to seek evaluation and/or treatment.

_____ _____

Printed Name – Parent or Legal Guardian Date

_____ _____

Signature Date

_____ _____

Signature of TUNCADD Witness Date