# *DISABILITY RIGHTS LAW CLINIC AY2008-2009*

NAME: ______________________________

☐ ACCEPT

☐ DECLINE

SIGNATURE: ________________________

*Clinic Administrative Fee $120.00
(Check or Money Order)

*Please return this form to the Clinic Office (Room 417) with your Clinic Administrative Fee by **April 7, 2008**.*

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CLINIC STAFF USE ONLY

Clinic Administrative Fee Received ☐ YES ☐ NO ______________________

- ☐ Check
- ☐ Money Order