

CENTER FOR VISION LOSS

INVITES YOU TO THE

TWO • THOUSAND • ELEVEN

Chrysalis AWARD DINNER

HONORING A BLIND OR VISUALLY
IMPAIRED PERSON WHO HAS
TRANSFORMED THE WORLD AROUND THEM

SATURDAY,
OCTOBER 29, 2011
6PM RECEPTION • 7PM DINNER

UNIVERSITY CENTER, DESALES UNIVERSITY
2755 STATION AVENUE
CENTER VALLEY, PA 18034

\$75 PER PERSON

OUR HONORED GUEST

DR. AMY BOWER
PHYSICAL OCEANOGRAPHER
WOOD'S HOLE OCEANOGRAPHIC
INSTITUTION, MA

OCEAN WITHOUT SIGHT

DR. BOWER STUDIES DEEP OCEAN CURRENTS USING STATE-OF-THE ART INSTRUMENTATION INCLUDING SPECIAL ADAPTIVE EQUIPMENT AND SOFTWARE THAT PERMIT HER TO LEAD EXPEDITIONS AT SEA IN SPITE OF BEING LEGALLY BLIND. DR. BOWER'S RESEARCH HAS TAKEN HER AS FAR AFIELD AS THE GULF OF ADEN, WHERE AN ENCOUNTER WITH PIRATES DID NOT DAMPEN HER ENTHUSIASM FOR EXPLORATION. SHE WILL ALSO DESCRIBE HER OUTREACH ACTIVITIES WITH THE PERKINS SCHOOL FOR THE BLIND, MA. WORKING WITH SCIENCE TEACHER KATE FRASER, DR. BOWER HAS DEVELOPED AN ACCESSIBLE EXPEDITION WEB SITE FOR THE STUDENTS AND ORGANIZED FIELD TRIPS FOR THEM TO VISIT WOOD'S HOLE AND MAKE THEIR OWN JOURNEY TO SEA IN VINEYARD SOUND NEAR CAPE COD.

IF INTERESTED IN ATTENDING, KINDLY RESPOND BY OCTOBER 19, 2011

NAME(s) _____

ORGANIZATION / COMPANY _____

ADDRESS _____

CITY / STATE / ZIP _____

PHONE _____

E-MAIL ADDRESS _____

PLEASE MAKE CHECKS PAYABLE TO
CENTER FOR VISION LOSS

I PREFER TO PAY BY CREDIT CARD

VISA MASTERCARD DISCOVER AMEX

CARD NO. _____

EXPIRATION DATE / SECURITY CODE _____

PHONE _____

SIGNATURE _____

I/WE WILL BE ATTENDING THE EVENT AT \$75 PER PERSON.

\$25 of this amount is tax-deductible to the extent provided by law

_____ Chicken Bruschetta

_____ Seared Jail Island Salmon Oscar

_____ Eggplant Rolatini

I/WE WISH TO BE A PATRON AT \$100 PER PERSON WHICH INCLUDES AN EVENT TICKET & A LISTING IN THE PROGRAM BOOK. *Please indicate your dinner choices above.*

LIST ME/US AS _____

I/WE CANNOT ATTEND BUT ENCLOSED IS A TAX DEDUCTIBLE CONTRIBUTION OF \$ _____

I/WE REQUEST THE FOLLOWING ACCOMMODATIONS OR DIETARY NEEDS _____

PLEASE RETURN THIS FORM WITH YOUR PAYMENT TO CENTER FOR VISION LOSS, 845 WYOMING ST., ALLENTOWN, PA 18103 BY OCTOBER 19, 2011.

SENDING IN THIS FORM
CONFIRMS YOUR RESERVATION.



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