



NFADB Membership Application

(Online Membership available - www.nfadb.org)

INFORMATION ABOUT YOU		
Name(s):		
Organization/Agency:		
Address:		
City:	State:	Zip:
Phone:	Email:	

FAMILY MEMBERS: INFORMATION ABOUT YOUR FAMILY MEMBER WHO IS DEAF-BLIND	
Name:	Birthdate:
Relationship to you:	
Cause of deaf-blindness:	

TYPE OF MEMBERSHIP		
INDIVIDUAL 1-year - \$15 <input type="checkbox"/> 3-year - \$35 <input type="checkbox"/> Lifetime - \$100 <input type="checkbox"/>	FAMILY 1-year - \$15 <input type="checkbox"/> 3-year - \$35 <input type="checkbox"/> Lifetime - \$100 <input type="checkbox"/> # of family members: _____	ORGANIZATION/AGENCY 1-year - \$100 <input type="checkbox"/> 3-year - \$250 <input type="checkbox"/>
I give permission to use my email address to sign me up for the NFADB listserv. Yes <input type="checkbox"/> No <input type="checkbox"/>		
FAMILIES: I give permission to share my name with other families who have a family member with similar etiologies, disabilities or challenges. Yes <input type="checkbox"/> No <input type="checkbox"/>		
How would you like to receive your NFADB newsletter?		Email <input type="checkbox"/> Regular mail <input type="checkbox"/>
Please indicate any accommodations needed: Large print <input type="checkbox"/> Braille <input type="checkbox"/> Spanish <input type="checkbox"/>		

Please make checks payable to NFADB and send to:

NFADB Membership
141 Middle Neck Road
Sands Point, NY 11050-1129

For questions, please call Lori at 1-800-255-0411 or NFADB@aol.com