



2010-11 NFADB Membership Application

Information about you		
Name(s):		
Address:		
City:	State:	Zip:
Phone:	Email:	

Information about the individual who is deaf-blind	
Name:	Birthdate:
Relationship to you:	
Cause of deaf-blindness:	

Information about your membership <i>(Click on the boxes to select)</i>
Please select your choice of membership. 1-year - \$15 <input type="checkbox"/> 3-year - \$35 <input type="checkbox"/> Lifetime - \$100 <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"/>
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"/>
Would you like materials in: Large print <input type="checkbox"/> Braille <input type="checkbox"/> Spanish <input type="checkbox"/>

Please make checks payable to NFADB and return your membership application and payment 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