NATIONAL FAMILY ASSOCIATION FOR DEAF-BLIND

Empowering Families with Individuals who are Deaf-Blind

MEMBERSHIP APPLICATION

Information About You

Name(s):

Organization/Agency:

Address:

City, state, zip:

Phone:

Email:

Information About Your Family Member Who is Deaf-Blind (if applicable)

Name:

Birth date:

Relationship to you:

Cause of deaf-blindness:

Type of Membership

Individual/Family:

☐ 1 – year: $15.00

☐ 3 – year: $35.00

☐ Lifetime: $100.00

Type of Membership (cont.)

Organization/Agency:

☐ 1 – year: $100.00

☐ 3 – year: $250.00

I/we give permission to share contact information with other NFADB members:

☐ Yes, all info

☐ Email only

☐ Phone number only

☐ No, please don't share

Please send this application and check payable to NFADB to:

NFADB Membership
PO Box 1667
Port Washington, NY 11050

For questions, contact Patti McGowan patti@nfadb.org

NFADB is a 501(c)3 nonprofit organization. All donations and membership fees are tax deductible within the extent of the law.