NATIONAL FAMILY ASSOCIATION FOR DEAF-BLIND

SUPPORTING PERSONS WHO ARE DEAF-BLIND AND THEIR FAMILIES

MEMBERSHIP APPLICATION

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	
HOUSEHOLD 1-year - $15 ☐ 3-year - $35 ☐ Lifetime - $100 ☐ # of family members: _____	**ORGANIZATION/AGENCY** 1-year - $100 ☐ 3-year - $250 ☐
I give permission to use my email address to sign me up for the NFADB listserv. Yes ☐ No ☐	
FAMILIES: I give permission to share my name with other families who have a family member with similar etiologies, disabilities or challenges. Yes ☐ No ☐	
Note specific topics of interest concerning deaf-blindness:	
Please indicate any accommodations needed: Large print ☐ Braille ☐ Spanish ☐	

There are two easy ways to join, go to www.nfadb.org/who-we-are/join-our-family/apply and fill out the membership application, payment can be made via paypal or credit card on the website. *OR* Complete Application and Mail: NFADB Membership PO Box 1667 Port Washington, NY 11050

For questions, please call Sue at 1-800-255-0411 or nfadbinfo@gmail.com