New York Parent Association for Deaf-Blind

Supporting Families of Individuals with Vision & Hearing Or Dual Sensory Loss in NYS

www.nypadb.org

NYPADB Membership Form 2016

Name: _____

Address: _____

City: _____ State: **NY** Zip: _____

Telephone: (____) _____ Mobile: (____) _____

Email: _____

Family Member with deaf-blindness: _____ DOB: _____

Check One Below:

□ Family Membership $15 Annually
□ Professional Membership $15 Annually
□ Lifetime Membership $100
□ Family Scholarship
□ Donation, amount _____ (Donations are tax-deductible!)

How did you hear about NYPADB? _____

Would you like to speak to an NYPADB Member? _____

Do you have an area of special interest? _____

Would you like to participate in a monthly Support Group via Conference Call?
____ DB Kids
____ CHARGE Syndrome

I would be interested in working on an event:
_____ Family Outing
_____ Fundraiser
_____ Workshop
_____ Family Retreat Weekend

I would be interested in joining the Board of Directors _____
I would be interested in helping with an event _____

Please mail this form with your check to:
NYPADB
c/**o** Audrey Dwyer
67 Vidoni Drive
Mt. Sinai, NY 11766