AADB INDIVIDUAL

MEMBERSHIP APPLICATION

New ___ Renew ___

MEMBER INFORMATION: Name: _____

Address:_____

City/State/Zip/Country: _____

E-mail: _____

Phone Number:_____

Text Number: _____

MEMBERSHIP CATEGORY: Please Check One:

ACTIVE – DeafBlind, US Residents _____

ASSOCIATE – Non DeafBlind, US Residents _____

INTERNATIONAL – Non US Residents, DeafBlind or Supporters _____

MEMBERSHIP TERM & DUES: Please Check one:

1 year: $15 ___ 2 years: $25 ___ 3 years: $30 ___ Lifetime: $500 ___

PLEASE LIST BELOW THE AMOUNT YOU ARE PAYING

Your Membership Dues $ _____

Tax-Deductible Donation $_____

Total Payment $ _____

All payments you choose can be completed by using PayPal. Go to this link: https://www.paypal.com/donate/?token=ESj97EyCqeQMQVQN5OJHUEarWSa0K3QaEWMZrdMXj2pzo_Tm4B6G2dko2FOJKy0b0jacnG&country.x=US&locale.x=US

In completion of this application and payments, please send this form to:

Sarah Goodwin, Treasurer: segoodwin@outlook.com

For AADB Purpose Only:

Date Received: _____

Total Amount received: _____