

MEMBERSHIP APPLICATION

PLEASE COMPLETE ALL SECTIONS OF THIS FORM AND MAIL IT WITH YOUR PAYMENT TO:

CACLD

25 Van Zant Street, Suite 15-5
East Norwalk, CT 06855-1719

New Membership Renewal Membership

PLEASE SEND ME MORE INFORMATION ON:

<input type="checkbox"/> Learning Disabilities (LD)	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Children	<input type="checkbox"/> Adults
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I AM A/AN

<input type="checkbox"/> LD Adult	<input type="checkbox"/> ADD/ADHD Adult	<input type="checkbox"/> Parent of a child/adult with <input type="checkbox"/> LD <input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Professional	<input type="checkbox"/> Other:	

NAME, DATE OF BIRTH AND GENDER OF LD/ADD/ADHD INDIVIDUAL(S)

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I WORK WITH

<input type="checkbox"/> Children	<input type="checkbox"/> Adolescents	<input type="checkbox"/> Adults
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LOCATION WHERE YOU WORK WITH LD/ADD/ADHD INDIVIDUAL(S)

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I WOULD LIKE TO BECOME A MEMBER

<input type="checkbox"/> \$40.00 Family Member/Parent	<input type="checkbox"/> \$100.00 Sustaining Member
<input type="checkbox"/> \$40.00 LD/ADD/ADHD Adult Member	<input type="checkbox"/> \$200.00 Sponsoring Member
<input type="checkbox"/> \$50.00 Professional Member	<input type="checkbox"/> \$1000.00 Life Member
<input type="checkbox"/> \$75.00 School, Agency, Organization	<input type="checkbox"/> \$_____ Additional Donation

PAYMENT METHOD

<input type="checkbox"/> Check / Money Order (enclose with this form when mailed)	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Visa	<input type="checkbox"/> American Express
Credit Card #:	Expiration Date:		
Signature:			
Name:			
Address:			
City:	State:	Zip Code:	
Home Phone:	Work Phone:	Email Address:	

My Employer will match my gift. Company Name: _____

Matching Gift form enclosed.