MEMBERSHIP APPLICATION

APPLICANT INFORMATION

Name:		
email:	Cell:	Phone:
Current address:		
City:	State:	ZIP Code:
Are you a past member? ________	If so when? __________	

DUES

Dues shall be paid per annum and shall be payable by January 31st. Allow 6wks. for membership card to be mailed.

FEES: (check one)		
Professional	$100	______
Clinic Name	_______________________	Email___________________________
Family	$50	______
Individual	$25	______
Person with ASD	$15	______

MEMBERS WILL RECEIVE

Access to our quarterly financial grant program. **Beginning in 2010 you must be a member to receive a grant.**

Membership card with established membership date

Emails of upcoming events, and newsletter

Voting rights at our annual meeting

Participation in our parent to parent networks

Discounts on conference fees

SPOUSE/ CHILDREN INFORMATION IF APPLING FOR FAMILY MEMBERSHIP

Spouse Name:		
Children's information	Autism dx? ________	Are you a past member?_______

Name/age	Name/age
Name/age	Name/age

SIGNATURES

I authorize the verification of the information provided on this form is accurate.

Signature of applicant:	Date:
Signature of spouse *(only if for a family membership):*	Date:
Make Checks payable to:	ANGEL, Inc.
Send application to:	Jennifer Larson E4549 Sherwood Dr. Spring Green, WI 53588
www.angelautismnetwork.org	**jennifer@angelautismnetwork.org**

A.N.G.E.L., Inc. is a registered non-profit 501c3 organization