

SBAWNY 2009 Membership Form

2009 Individual/Family Memberships:

First & Last Names of all Family Members (or people in household)	Ages (children)	Please note if the person(s) listed have Spina Bifida, Hydrocephalus or other Neural Tube Defect	Birth Date (children)	Please note relationship of each person listed to the Person with Spina Bifida	Email Addresses: (This will allow us to disseminate infor- mation quicker)

Street Address: _____

City, State, Zip: _____

County: _____ Phone Number(s): _____

Membership dues are on a sliding scale to enable you to give as much as you can for our programs and services. We value your membership and financial support. Please circle one of the following dollar amounts and mail a check or money order for that amount to the address below.

\$15, \$20, \$25, \$30, or \$35: Local Chapter family/individual membership

2009 Professional Memberships:

Contact Name: _____ Organization: _____

Title of Contact: _____ Relationship to SBAWNY: _____

Street Address: _____

City, State, Zip: _____

County: _____ Phone Number(s): _____

We value your membership and your financial support. Please choose your organization's membership level .

Gold (\$500) Silver (\$250) Bronze (\$150) Professional (\$50)

Please make checks payable to SBAWNY and mail with this form to:

SBAWNY, 137 Warner Ave., North Tonawanda, NY 14120