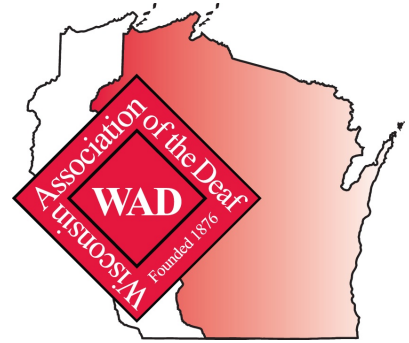


Wisconsin Association of the Deaf

Membership Form



Please print clearly.

Full Name: _____

Spouse/Partner's Full Name: _____

Address: _____

City, State, Zip: _____

County: _____

Email Address: _____

Phone: (TTY/Voice/VP) _____

I would like to receive WAD Newsletter by: (Check one)

E-mail

Postal Mail

Both

Membership dues are good for two years.

Individual	\$15	\$
Married Couple	\$25	\$
Senior (age 50+)	\$10	\$
Senior Couple	\$15	\$
Student/Associate (non-resident)	\$10	\$
Donations welcome		\$
TOTAL		\$

Date of payment received _____ Amount _____ Cash or Check # _____

THANK YOU FOR YOUR SUPPORT!