



## MEMBERSHIP FORM

Becoming a member of the Eastern Pennsylvania Down Syndrome Center (EPDSC) connects you with a Down syndrome support network, programs for individuals with Down syndrome, and resources for families, community members and professionals. You'll also play an important role in shaping the future of the center as we reach out to membership frequently for feedback and to find out what your needs are.

**Please complete the information below, choose your membership package and return this form to [theepdsc@gmail.com](mailto:theepdsc@gmail.com). Payment can be made via PayPal online at [www.epdsc.net](http://www.epdsc.net) or mailed to the address below.**

Today's Date : \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_

Names of Immediate Family Members Living in the Same Household (excluding parents):

\_\_\_\_\_  
\_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_

County: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email address: \_\_\_\_\_

The following information is **OPTIONAL** and will be kept confidential: It will be used when applying for certain grants:

Race: \_\_\_\_\_ Household Size: \_\_\_\_\_ Family Income: \$ \_\_\_\_\_/Year

Choose the membership level you would like to receive (circle one):                      Membership Expiration: \_\_\_\_\_

- Family Membership (\$30)
- Lifetime Membership (\$300)
- New & Expecting Parents Program 1st Year member (FREE)
- Complimentary Trial Membership - Must be approved in advance.

I would like to contribute an additional donation of \$ \_\_\_\_\_ along with my membership.

If applicable, please tell us about a person in your household with Down syndrome:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Your relationship to this individual: \_\_\_\_\_