



2019 FCDSN Membership Application Form

For more information, please refer to the "Terms and Conditions of FCDSN Membership" @ www.fcdsn.com

NEW First Time Members Only (**FREE first year**)

RENEWAL

Your **\$35 yearly dues** entitle you to: participate in age-appropriate Social Groups and activities, attend Member Appreciation events, eligibility to apply for our various Cash Reimbursement Programs, and more.

Type of Membership: Individual \$35 Family \$35 Professional/Organizational \$35 First Time (**FREE**)

Name: _____ Date: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Email **primary**: _____

Email **secondary**: _____

(Please print email address clearly as we will be using this to communicate with you throughout the year)

Name of Person with Down syndrome: _____

Gender: Male Female Birth Date: _____

Relationship to Applicant:

Son Daughter Sibling Grandchild Self other: _____

The following information is **optional** and will be kept confidential.

It will be used only when applying for certain grants:

Race: _____ Household Size: _____ Family Income: \$ _____/year

Education Level of Parents: Mother _____ Father _____

Please Note: Pictures are often taken at FCDSN events that are then shared with our organization. If you prefer that your picture NOT be published, check here:

Please fill out this form completely and mail it with a \$35 check made payable to FCDSN, to:

FCDSN Membership, 2117 Buffalo Road #132, Rochester, NY, 14624

Do Not Write In Box Below

Processed by: _____ Date: _____
Reply Mailed On: _____ Amount: \$ _____
 Cash Check No. _____ Verified in Mail Chimp: _____