



MEMBERSHIP FORMS

REGISTERED CHARITY # 590

Member Name: _____

Mailing Address: _____

Contact Numbers: Home: _____ Work: _____

E-Mail: _____

- Parent
 Professional: (Please tick one)
 Dr
 OT
 PT
 SLP
 Aide-
 Teacher
 Other _____

PARENT PLEASE COMPLETE

Children (diagnosed and siblings)

Name	Birth date	Sex	Diagnosis
_____	___/___/___ D M Y	___	_____
_____	___/___/___ D M Y	___	_____
_____	___/___/___ D M Y	___	_____
_____	___/___/___ D M Y	___	_____

PROFESSIONALS PLEASE COMPLETE

Would you like your name and number posted on our general membership list? **Y/N**
(This list would be available to ALL members)

Would you like your name and number posted on our professionals list? **Y/N**
(This list would be available only to the professionals in our membership and the executive committee)

AREAS OF INTEREST

- Speech
 Physical therapy
 Occupational therapy
 Sensory integration
 Behavioral therapy
 Education
 Diet
 Other _____

Membership dues are \$25 per year. Send completed membership form with dues to:
P.O. Box FL 93, Flatts FL BX, Bermuda