



Brain Injury Association of Arizona

Membership Application

Please complete all sections of this form. Membership covers a calendar year beginning the month of receipt of your application.

Today's Date _____

Last Name, First Name, Middle Initial, Suffix

Organization / Company

Address

City, State, ZIP

Phone / FAX

E-Mail

Please check one

- ____ Survivor
____ Family Member / Caregiver
____ Friend
____ Professional
____ Specialization: _____

Membership Categories

Includes quarterly newsletter, notification of conferences and events, public policy updates and national publications, and listing in our annual report and website.

- ____ Lifetime Member, \$1,000 and above
____ Corporate Member, \$500 to \$999
____ Circle of Friends, \$76 to \$499
____ Professional, \$75
____ Basic, \$35
____ Courtesy/Special Rate, \$5
____ Please list my membership/contribution as
____ "anonymous" in all public listings

The courtesy / special rate is for persons with a brain injury or family members who have limited resources. The \$5 fee will help process your application and in the mailing of materials. Benefits are the same as a basic membership. Membership will not be denied to anyone based on his/her ability to pay.

____ Please call me... I would like to volunteer! Phone # _____

If you wish to charge your membership payment, please complete:

____ VISA ____ MasterCard ____ American Express
_____ Exp. Date _____

Signature _____

Please make your check payable to the:
Brain Injury Association of Arizona
and mail to:

777 E. Missouri Ave.
Suite 101
Phoenix, AZ 85014