



# CCPD Membership Application

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Name of Group or Organization: \_\_\_\_\_

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

City/State/Zip or Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Are you presently involved with disability? \_\_\_Yes \_\_\_ No

If yes, what is your involvement?

\_\_\_\_\_

Is your involvement  Full Time  Part Time  Voluntary

Types of disabilities served?

- |   |   |
|---|---|
| <input type="checkbox"/> Physical Disabilities      | <input type="checkbox"/> Cognitive Disabilities   |
| <input type="checkbox"/> Deaf/Hard of Hearing       | <input type="checkbox"/> Blind/Low Vision         |
| <input type="checkbox"/> Environmental Disabilities | <input type="checkbox"/> Brain Trauma             |
| <input type="checkbox"/> Learning Disabilities      | <input type="checkbox"/> Age-related Disabilities |
| <input type="checkbox"/> Mental Illness             | <input type="checkbox"/> Chronic Illness          |
| <input type="checkbox"/> Care givers                | <input type="checkbox"/> Other: _____             |

I have Read the CCPD Statement and agree with it.

I will pray for the ministry of CCPD.

My Membership Category is:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Individual (\$50)   | <input type="checkbox"/> Church (\$100)     | <input type="checkbox"/> Non-profit Organization (\$100) |
| <input type="checkbox"/> Contributor (\$250) | <input type="checkbox"/> Benefactor (\$500) | <input type="checkbox"/> Corporation (\$1000)            |

Student (\$25) List Name and address of the school you are enrolled at:

\_\_\_\_\_

In addition to my annual dues, I will to make a donation of \$\_\_\_\_\_

Please subscribe me to the *Journal of Religion, Disability and Health* at the discounted rate of \$48.00 (payment Enclosed)

Total Enclosed: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_