



Date: _____

CAPED Membership
(Membership valid from October 1 through September 30)

Name: _____

College/Affiliation: _____

Department/Title: _____

Preferred Mailing Address: _____

Phone (Please note Voice or TTY)

Work: _____

Home: _____

Fax: _____

Email: _____

Membership Status

- New
 Continued Renewal
 Renewal after lapse of _____ months

Institutional \$240/yr. \$ _____

An institution, corporation, or other organization interested in supporting and promoting the mission of CAPED is an institutional member. An institution will designate, by name, up to four individuals to receive benefits of membership. Each institution member designee is eligible to vote, join CIGs, and be an officer of the Association as stipulated under Article II, Section I-A, B, or C of these bylaws (Please list Members name and Email on lines below):

CAPED Interest Groups:

Dues:

- | | |
|---|------|
| <input type="checkbox"/> Adapted Physical Education | \$10 |
| <input type="checkbox"/> Access Technology | \$10 |
| <input type="checkbox"/> Counseling/
Career Development | \$10 |
| <input type="checkbox"/> Deaf/Hard-of-Hearing | \$10 |
| <input type="checkbox"/> Intellectual Disabilities /
Developmental Disabilities/
Autism | \$10 |
| <input type="checkbox"/> Learning Disabilities | \$10 |
| <input type="checkbox"/> Program Management | \$10 |
| <input type="checkbox"/> Veteran | \$10 |

Professional \$80/yr. \$ _____

Faculty, professional, certificated or other similar salaried staff actively working with students with disabilities.

Donations: Student Scholarship: \$ _____

Associate \$40/yr. \$ _____

Support service or part-time hourly staff.

Retired \$40/yr. \$ _____

Student \$18/yr. \$ _____

Full time students who do not meet one of the categories above. (faculty verification required)

Library \$20/yr. \$ _____

All mailings and the Communiqué

Total Dues & Donations	\$ _____
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Method of Payment (check one if not including a check or purchase order). MasterCard Visa Check # _____

VCODE _____ (3-digit # on back of card)
 Cardholder's Name as it appears on card: _____
 Card Account Number: _____
 Exp. Date (required): Month _____ Year _____ Zip Code (Billing address) _____
 Cardholder's Signature: _____

Please make checks payable to CAPED. Your check is your receipt. (Dues and donations are tax-deductible to the extent permitted by law.)

Mail completed application and fees to:
 Allison Brown, CAPED ♦ 10073 Valley View St. #242 ♦ Cypress, CA 90630
Caped38@gmail.com; Fax: 866-577-3387