



TASH Membership Form

Organization Name (If applicable): _____

Organizational members must fill out the following fields for the Primary Contact only. To submit five staff members that would like to receive TASH benefits, please attach the Organization Member Sub-Account Form (available at www.tash.org/join).

First Name: _____ Last Name: _____

Address: _____

City/State/ZIP: _____ Country: _____

Phone: _____ E-mail: _____

Membership Level

TASH offers membership at a variety of levels. Please review the details below and choose the membership level that is appropriate for you. Individual and organizational memberships are available. Membership is valid for a 12 month term. A complete summary of member benefits can be found at www.tash.org/join.

	Regular	Reduced			Organization \$385
	Professional \$165	Associate \$85	Self-Advocate, Family & Sup- porter \$35	Student \$45	
Research and Practice for Persons with Severe Disabilities, the official TASH research journal (print copy)	X				1 COPY
Research and Practice for Persons with Severe Disabilities, (online access to current and archived issues)	X	X		X	X
Connections, the quarterly magazine written by and for TASH members	X	X	X	X	X
Connections Library (includes access to 10 years of Connections archives)	X	X			X
TASH webinar archive	X				X
Reduced registration rates for TASH conferences and events	X	X	X	X	5 STAFF
Discounts for TASH Training webinars, publications & other offerings	X	X	X	X	5 STAFF
Access to TASH's professional network, forums & blogs	X	X	X	X	X
Affiliation with a TASH Chapter (includes policy and expertise, Capitol Hill Days, Chapter communications & activities)	X	X	X	X	X
Advocacy Alerts & Updates	X	X	X	X	X
	<input type="checkbox"/> Select	<input type="checkbox"/> Select	<input type="checkbox"/> Select	<input type="checkbox"/> Select	<input type="checkbox"/> Select

Demographic Information

This information is collected for TASH's use only so that we can better serve our members' needs.

What is your race or ethnicity? (Optional; select all that apply)

- American Indian or Alaska Native
- Native Hawaiian or Pacific Islander
- Asian
- Black or African American
- White/Caucasian
- Hispanic/Latino
- Other _____

Which of the following best describes you? Select all that apply. (not applicable for organizational members)

- | | | |
|--|--|---|
| <input type="checkbox"/> General Educator | <input type="checkbox"/> Person with a disability | <input type="checkbox"/> Government – Federal |
| <input type="checkbox"/> Special Educator | <input type="checkbox"/> Parent of a person with a disability | <input type="checkbox"/> Government – State |
| <input type="checkbox"/> Education Administrator | <input type="checkbox"/> Sibling of a person with a disability | <input type="checkbox"/> Government – Local |
| <input type="checkbox"/> Transition Educator | <input type="checkbox"/> Other family member of a person with a disability | |
| <input type="checkbox"/> University Faculty | | <input type="checkbox"/> Attorney |
| <input type="checkbox"/> University Researcher | <input type="checkbox"/> Early Intervention Service Provider | <input type="checkbox"/> Public Policy Advocate |
| | <input type="checkbox"/> School-Aged Related Service Provider | <input type="checkbox"/> Other Advocate |
| | <input type="checkbox"/> Adult Service Provider | <input type="checkbox"/> Other _____ |

Please indicate your areas of interest. Select all that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> Early Childhood | <input type="checkbox"/> Community Living | <input type="checkbox"/> Assistive Technology |
| <input type="checkbox"/> K-12 Education | <input type="checkbox"/> Aging Issues | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Transition | <input type="checkbox"/> Advocacy | <input type="checkbox"/> Diversity & Cultural Competency |
| <input type="checkbox"/> Post-Secondary Education | <input type="checkbox"/> Public Policy | <input type="checkbox"/> Human Rights |
| <input type="checkbox"/> Employment | <input type="checkbox"/> International Issues | <input type="checkbox"/> Other _____ |

Additional Information

Your Date of Birth (Optional): _____/_____/_____

If you are a family member of a person with a disability, fill out the date of birth of your family member: _____/_____/_____

If you are a student, please fill out the following fields:

University Name: _____ Expected Completion Date: _____

Major/Department Name: _____

If you are a university educator, what is your field of study? _____

Payment Information

Credit Card (select card type)

- American Express Visa
 MasterCard Discover

Check (make payable to TASH)

Purchase Order

P.O. #: _____

(send copy with membership form)

Card #: _____ Expiration: _____

Name on Card: _____ CVV: _____

Authorized Signature: _____

Would you like to make a tax-deductible donation to TASH?

- \$10 \$25 \$50 \$100 \$ _____

Total Payment (add membership total and donation, if applicable) \$: _____

Please submit this membership form via mail, fax or e-mail. With questions, contact (202) 540-9020.

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Washington, DC 20006

Fax (202) 540-9019

E-mail info@tash.org

www.tash.org to learn more about TASH

www.tash.org/join for an overview of member benefits

