Prader-Willi California Foundation
Supporting People with Prader-Willi Syndrome

MEMBERSHIP APPLICATION

DATE:_____

NAME: _____
First Name(s) Last Name

AFFILIATION: _____
Professional Title/Organization

ADDRESS: _____
Street Apartment Number City State Zip

TELEPHONE: _____ _____
Home Work

CELL PHONE: _____ **E-MAIL**: _____

Your Relationship to Individual with PWS: ❒Parent/Guardian ❒Sibling ❒ Grandparent ❒Aunt or Uncle
❒Family Friend ❒Residential or Vocational Service Provider ❒Other _____

Name of Individual with PWS: _____
First Last

Birth Date: _____/_____/_____ **Age:** _____ **Sex**: ❒Male ❒Female **Date of Diagnosis:** _____

Child's Ethnicity: (check all that apply): ❑African American ❒Asian ❒Caucasian ❒Hispanic/Latino ❒Native American

Diagnosis Type: ❒Deletion ❒UPD ❒Imprinting Mutation ❒Translocation ❒Clinical ❒Other _____

Regional Center Affiliation: _____

Physician's Name, Hospital Affiliation: _____

Your Occupation(s) or Areas of Interest or Expertise: _____

Total Household Income (for grant writing purposes only): ❑Less than $10,000 ❑$10,000 to $19,999 ❑$20,000 to $29,999
❑$30,000 to $39,999 ❑$40,000 to $49,999 ❑$50,000 to $59,000 ❑$60,000 to $69,999 ❑$70,000 to $79,999
❑$80,000 to $89,999 ❑$90,000 to $99,999 ❑$100,000 to $149,999 ❑$150,000 or more

Language(s) You Speak in Addition to English: _____

❒**Send Quarterly Newsletter via Email** ❒**Mail Quarterly Newsletter to the above Street Address**

Committee Work: I am interested in learning about these committees: ❒Legislative Affairs ❒Finance ❒Fundraising
❒Newsletter ❒Program ❒Public Awareness ❒Publications ❒Residential Services ❒Other _____

Sharing List: ❒You may share my name with other families for support and networking purposes ❒I'd like to join a Support Group
❒Please keep my name confidential, available only to PWCF officials

Are you a member of PWSA (USA)? ❒Yes ❒No ❒Please send me PWSA (USA) membership information [Sent ___]

Signature: _____

Membership Dues Information

Membership Categories		Annual Dues
❒ Individual: *Single Parent/Individual with PWS*	(Entitles one vote)	$30
❒ Family: *Parents/Primary Caregivers*	(Entitles two votes)	$45
❒ Professional: *Physician/Provider/Association*	(Entitles one vote)	$60
❒ Extended Family: *Grandparent/Aunt/Uncle/Sibling*	(No Voting Privileges)	$45
❒ Family Friend: *Friend of the Family*	(No Voting Privileges)	$30
❒ I/we cannot afford dues at the time but wish to become a PWCF member. I have checked the box above to show the correct membership category.		
❒ Tax-Deductible Donation		$_____
Total Amount		$_____

Office Use Only
Date:_____
Dues Amt.:_____
Donation Amt.:_____
Ck No.:_____
❒DB ❒XL ❒QB ❒NSL
❒New Member Handbook
❒Donation Receipt

❑ I have enclosed my check made payable to Prader-Willi California Foundation
❑ Please charge $_____ to my ❑Visa ❑MC ❑AMX Name on Card: _____
Card No.: _____ Exp. Date: _____ Security Code: _____

Prader-Willi California Foundation is a 501(c)(3) tax exempt charitable organization.
Membership dues are not tax deductible. Donations are tax deductible as a charitable donation to the extent permitted by law.
Your annual membership includes a subscription to the quarterly newsletter, *PWCF News*.

Please return this Membership Application to Prader-Willi California Foundation
514 N. Prospect Avenue, Suite 110-Lower Level, Redondo Beach, CA 90277
(800) 400-9994 (Within CA) • (310) 372-5053 • Fax (310) 372-4329 • info@pwcf.org • www.PWCF.org