pwcf .org 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 **Height:** ________ **Weight:** _________

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

Diagnosis Type: ❐Deletion ❐UPD ❐Imprinting Mutation ❐Clinical ❐Other _________ **Date of Diagnosis:** __________
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)	$40
❐ Family: *Parents/Primary Caregivers*	(Entitles two votes)	$55
❐ Professional: *Physician/Provider/Association*	(Entitles one vote)	$70
❐ Extended Family: *Grandparent/Aunt/Uncle/Sibling*	(Entitles one vote)	$55
❐ Family Friend: *Friend of the Family*	(No Voting Privileges)	$40
❐ 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
1855 First Avenue, Suite 201, San Diego, CA 92101
(800) 400-9994 • (310) 372-5053 • Fax (310) 372-4329 • info@pwcf.org • www.PWCF.org