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

MEMBERSHIP APPLICATION

Date: _____

Name(s): _____
Mother or Her Name Father or His Name

Affiliation: _____
Professional Title/Organization

Address: _____
Street Apartment Number City State Zip

Home Phone: _____ **Her Cell:** _____ **His Cell:** _____

Her Email: _____ **His Email:** _____

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

Language(s) you speak other than English: _____

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

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

Would you like us to share your information with the national PWSA | USA? ❒Yes ❒No [Shared: _____]

This information is optional and helps us with our grant writing. Total Household Income:
❒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

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:** _____

Physician's Name, Hospital Affiliation: _____

Regional Center Affiliation: _____ ❒Eligible ❒Denied ❒Dropped ❒Never Applied

Signature: _____

Membership Dues Information

Membership Categories		Annual Dues
❒ Family: *Parent(s)/Primary Caregiver/Individual w/ PWS*	(Entitles one vote)	$55
❒ Professional: *Physician/Provider/Teacher/Association*	(Entitles one vote)	$100
❒ I/we cannot afford dues at this 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:_____
Donate Amt: _____
Ck|CC#:_____
❒DB ❒Accounting
❒Donation Receipt
❒Member Handbook
❒Parent Mentor_____
❒Support Group _____

❒ 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.

Please return this Membership Application to Prader-Willi California Foundation
1855 First Ave, Suite 201, San Diego, CA 92101
(800) 400-9994 • (310) 372-5053 • Fax (310) 372-4329 • info@pwcf.org • www.PWCF.org