

ASRC Membership Form

Please fill out the form completely so that we can accurately process your membership. All information given to ASRC will be held as confidential and not shared with anyone. Providing us with complete information will ensure that you receive all mailings relevant to you and your family, and/or your practice or service.

Personal Information

Renewal _____ New Member _____

First Name: _____ Last Name: _____

Organization Name: _____ (if applicable)

Address: _____, Apt. # _____, P.O. Box _____, Suite/Floor _____

City: _____, State: _____, County: _____ Zip code _____

Day phone w/area code () _____ Eve. phone w/area code () _____

Email address: _____ (The **MAJORITY** of notices and updates from our Center will be sent to you via email. Failure to give us your email address **may prevent** you from receiving these important notices, including annual membership reminders.)

For Individual/Family Membership

I am a(n) (check only one):

Parent/family member

If parent/family member of an ASD child, please provide the following:

Birthdate (with year) of child ____/____/____ ** Male _____ Female _____

ASD Diagnosis Asperger's syndrome Classic Autism High-Functioning Autism
 Non-verbal Learning Disability PDD-NOS Unknown

Dual Diagnosis (if any) _____

***Please note: For more than one diagnosed child, please fill out information on page 2 with child(ren)'s information.*

Adult with an autism spectrum disorder

My birthdate (with year) ____/____/____ Male _____ Female _____

ASD Diagnosis _____, Dual Diagnosis (if any) _____

For Private Practitioner Membership

I am a (check only one):

Private practitioner

Please specify: psychologist, OT, camp, etc. _____, _____

For Community Provider/Educator Membership

I am a(n) (check only one):

Educator/Birth to Three

Please specify: sp. ed. teacher, speech/language, OT, etc. _____

Please indicate district or private school _____ grade _____

Community Provider for service agency (i.e. Birth to Three, DMR, BRS)

Please specify: job coach, respite, case mgr., etc. _____

Agency _____

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Contacts:

_____ I would like information about support groups (ASRC will call you with local information).

_____ I would like to make a tax deductible contribution in the amount of : \$_____

Please note: The CT Autism Spectrum Resource Center is a 501 (c) (3) organization.

Payment

ASRC yearly Membership (includes ASRC Network newsletter, 4 per year). \$30.00

Email/mailling list only. Email/mailling notifications of upcoming events and announcements.

_____ I am sending a check in the amount of \$_____ (made out to ASRC)

_____ I would like to charge my (*check one*) VISA _____ Mastercard _____ Discover _____

Name as it appears on card: _____

Card number: _____ Expiration date on card: _____

For Additional Diagnosed Children from page 1, please fill out the information below:

1. Birthdate with year ____/____/____ of child Male ___ Female ___

ASD Diagnosis_____, Dual Diagnosis (if any) _____

2. Birthdate with year ____/____/____ of child Male ___ Female ___

ASD Diagnosis_____, Dual Diagnosis(if any) _____

You can also register as a member online at www.ct-asrc.org

ASRC, 101 North Plains Industrial Rd., Harvest Park, Building 1A, Wallingford, CT 06492

Phone: 203-265-7717, Fax: 203-265-7768

Email: ct-asrc@sbcglobal.net