



Membership Application And Renewal Form

Membership Year: July 1, 2009 – June 30, 2010

Organization Name: _____
(As it should appear on your Certificate of Membership and CDSA Records)

| | | | |
|----------------------------------|-----|----------------------------------|-----|
| Name of Principal Representative | | Name of Alternate Representative | |
| Title | | Title | |
| Address | | Address | |
| City, State, Zip | | City, State, Zip | |
| Phone | Fax | Phone | Fax |
| E-mail Address | | E-mail Address | |
| Web Site | | | |

Each member organization is entitled to as many representatives as desired. Please provide contact information for each alternate.

Membership Categories

Indicate your Membership Category:

SERVICE PROVIDER

Program/Organization must be vendorized by a Regional Center, or certified by the Department of Rehabilitation.

AFFILIATE

Service providers with a differentiated CDSA representation model (must align with one of the named groups in the affiliate category), or non-service providers supporting or involved with activities of CDSA member organizations.

