Membership Application

Choose One: New Member Renewal Withdraw Name

Name of Parents: ____

Name of Child with Down Syndrome: ____________________________________

Date of Birth: ____________________

Names of Siblings: ____

Address: ____

____

Phone Number: _______________ **Email Address:**_____________________________

Please provide your Title and/or Organization if applicable:

____

Explain briefly any medical, educational, or other issues you have experienced with your child that you could help another parent through (use other side if needed):

Schools your child has attended:

Names of medical or other professionals you would recommend:

Optional Donation $__________

Make check payable to	DSNMC
Mail to	DSNMC PO Box 10416 Rockville, MD 20849