

# IMPACT Membership Application

Independently Merging Parent Association of California Together for Deaf and Hard of Hearing Children

Be Informed . . . Join IMPACT Today!!

Last Name: _____		First Name: _____	
Titles: _____			
Name of Other Adult: _____			
Address: _____			
City: _____		State: _____	Zip: _____
Home Phone: (____) _____ v/tty			
Work Phone: (____) _____ v/tty			
E-Mail: _____		Fax: _____	
Affiliation:    ___ Parent    ___ Student    ___ Business    ___ Organization			
___ Legislator    ___ Other _____			
___ Professional			
Organization: _____			
Department: _____			
Role/Position: _____			

Enclosed is my contribution to be a(n):

\_\_\_ Advocate \$500    \_\_\_ Supporter \$200    \_\_\_ Booster \$100    \_\_\_ Family/Individual \$30.00

\_\_\_ New Member

\_\_\_ Renewal Member

**Please Make Checks Payable to:**  
IMPACT Treasurer  
PMB #287, Post Office Box 57033  
Irvine, California 92619-7033