



Membership Application

Name: _____

Mailing Address: _____

City: _____ **State :** _____ **Zip:** _____

Phone: _____ **Video Phone:** _____

E-mail address: _____ **Pager:** _____

Do you want to be on our email list?

Yes No

Date of Birth: _____

Language preference: (Check one)

- English
 American Sign Language / SE
 Other: _____

Special Interests (check all that apply):

- Deaf/HoH consumer
 Working interpreter
 ASL/Interpreter Student
 Employed in D/HH related field
 Parent of Deaf and Hard of Hearing child
 Family member of Deaf adult
 Friend of Deaf adult(s)
 Other: _____

Gender: Male Female **Membership category:** Single Family

Membership Fee: Family \$30.00 Single \$20.00 Senior Citizen—Free

Payment Information:

Amount Paid \$ _____ Check No. _____
 Cash

By signing below, I agree to abide by Southeastern Virginia Society of the Deaf's (SVSD) membership code of conduct, I certify that I am eighteen (18) years of age or older. I also understand that S.V.S.D. does not grant refunds for annual membership dues.

New Member Signature: _____

Name (Printed): _____ **Date:** _____

Treasurer Signature: _____ **Date:** _____

Beth Whyte, Treasurer
Treasurer@vbdeaf.com

Send completed application and fees to:
P.O. Box 15645 Chesapeake, VA 23328

For SVSD use only:

ID card Number: _____ **Membership dates:** ___/___/___ to ___/___/___

Notes: _____