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## Membership Form

- I'd like to:**
- Become a member of the Hearing Loss Association of America
  - Renew my membership
  - Give a gift membership (USA only)

Below is the gift recipient's information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

USA Membership Fees	
Individual	<input type="checkbox"/> \$35 (1 year)
Couple/Family	<input type="checkbox"/> \$45 (1 year)
Professional	<input type="checkbox"/> \$60 (1 year)
Library/Nonprofit	<input type="checkbox"/> \$50 (1 year)
Student	<input type="checkbox"/> \$20 (1 year)
Corporate	<input type="checkbox"/> \$300 (1 year)
Non-USA Membership Fees	
Individual	<input type="checkbox"/> \$45 (1 year)
Couple/Family	<input type="checkbox"/> \$55 (1 year)
Professional	<input type="checkbox"/> \$75 (1 year)
Library/Nonprofit	<input type="checkbox"/> \$75 (1 year)
Corporate	<input type="checkbox"/> \$325 (1 year)

**I would also like to include a donation in the amount of:**

\$ \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

(Billing address for credit card charge)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Chapter I belong to: \_\_\_\_\_

CREDIT CARD PAYMENT INFORMATION	
<input type="checkbox"/> American Express	<input type="checkbox"/> Discover
<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA
Card Number: _____	
Expiration Date: _____	Security Code: _____
Name: _____	(as it appears on your credit card)
Signature: _____	

PAYMENT	
Membership Fee	\$ _____
Donation	\$ _____
Total	\$ _____