



Date: _____

Title: (Mr./Mrs./Ms./Dr./Prof/...)_____

Name: _____ Phone: () _____

Address: _____ Alt Phone: () _____

City: _____ State: _____ Zip: _____

Spouse: _____ Email: _____

Relationship to person with Down Syndrome (Ds)?

Self / Parent /Grandparent /Sibling /Friend /Professional /None

Name of person with Ds? _____ Sex: M F

Birthday: _____ *

Membership Type:

Free ** / Non-family \$15.00 Per year / Professional \$15.00 Per year

If you wish to receive our quarterly newsletter check here:

Mail application to:

LADSS
RR #1 Box 196
Chatsworth, IL 60921

Membership Fee: _____
Donation: _____
Total Enclosed: _____

This application is available online at www.ladss.org. Questions or comments can be directed to (815) 689-2202 or email: david@ladss.org

LADSS is a not for profit charitable organization. * By applying for membership you are consenting to the Livingston Area Down Syndrome Society storing this information for the purposes of keeping you informed of services and activities that may be of interest to you. None of this information will be given or shared with entities outside the organization. ** Currently there is no fee for persons with Down syndrome or their family up through grandparents.

Signature: _____