

# NYSADSP

## New York State Association of Day Service Providers MEMBERSHIP APPLICATION FOR 2010

### Please Indicate Membership Level Below

- ( ) **Provider- \$275.00** This includes a Provider member plus two additional Associate members
- ( ) **Associate Member \$50.00** (additional after the above two Associate members)
- ( ) **Independent \$15.00** Family members and support staff joining NYSADSP independent of the agency they work for.

**ALL APPLICATIONS DUE BY March 12, 2010**

Please complete the following information exactly as you would like it to appear in the directory.  
Print Clearly

**Provider Member Name:** \_\_\_\_\_

Title: \_\_\_\_\_

Agency: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_ Day Habilitation \_\_\_ Day Treatment \_\_\_ Other (specify) \_\_\_\_\_

### Provider Members:

Please provide the following information (will not be included in the directory)

Executive Director: \_\_\_\_\_

Agency Main Address:

Street \_\_\_\_\_

City / Zip Code: \_\_\_\_\_

Main Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Amount Enclosed: \_\_\_\_\_

Make Checks payable to:

New York State Association of Day Service Providers  
C/O Chris Olander  
60 East Market St. #200  
Corning, NY 14830

**NYSADSP**  
**MEMBERSHIP APPLICATION**  
**2010**  
**ASSOCIATE MEMBERS**

**Please complete the following information exactly as you would like it to appear in the directory.**  
**Print Clearly. If you have more than two Associate members, please make copies.**

**1. Associate Member Name:** \_\_\_\_\_

Title: \_\_\_\_\_

Agency: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_ Day Habilitation \_\_\_ Day Treatment \_\_\_ Other (specify) \_\_\_\_\_

**Please complete the following information exactly as you would like it to appear in the directory.**  
**Print Clearly**

**2. Associate Member Name:** \_\_\_\_\_

Title: \_\_\_\_\_

Agency: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_ Day Habilitation \_\_\_ Day Treatment \_\_\_ Other (specify) \_\_\_\_\_