OPTION

Individual Associate Membership Application

Contact Information:

Name: ____

Address: ____

Phone: ______________________ Fax: ______________________

Email: ____

Website (if applicable):______________________________

Definition:

- Must be an individual defined as a person not representing a program, university, hospital, non-profit clinic, or advocacy program
- Must support the OPTION mission of advancing excellence in listening and spoken language education for children who are deaf and hard of hearing

Application Packet Checklist:

☐ Completed Individual Associate Membership Application

☐ One letter of support from a current OPTION Regular Member

Process:

- Following administrative review of the application, it will be subject to a 15-day period of comment from the OPTION Regular Membership.
- Following the 15-day comment period, the Individual Associate Member must be approved by a majority vote of OPTION Executive Board Members.
- Individual Associate Member dues of $100.00 will be invoiced upon approval of application.

To Maintain Individual Associate Membership:

- Pay assigned annual dues in accordance with the established deadlines

I certify that all information included in this OPTION, Inc. membership application is true and accurate. I understand that I will be billed for membership dues if this application is approved and membership privileges will not begin until dues are paid.

______________________________ ______________________

Name, Title (please print) Date

______________________________ ______________________

Signature Date

Please scan/email application to office.support@optionschools.org

Office Use Only Date Received: ______________ Fwd to Executive Board: ______________

Notes: