**Silicon Valley Council of the Blind**

**SVCB Membership Application Form and Instructions**

**rev. 05/17/19**

**Instructions**

**Complete the application form (next page) and submit it along with the appropriate dues (see below) to:**

**Silicon Valley Council of the Blind**

**P. O. Box 493**

**Mountain View, CA 94042-0493**

**If mailed in, do not submit cash. If hand-delivered to the membership chairperson, cash can be accepted.**

**Dues:**

**$10 per calendar year with the following exceptions:**

* **$7 per year for members where SVCB is not their home chapter; the other chapter pays to CCB.**
* **$7 for life members of CCB (contact CCB at 800-221-6359 about this designation) .**
* **$13 for a two-year membership initiated July 1-December 31 (for the remainder of the current year plus all of the next year).**

**Note: Multiple years dues can be paid at any time.**

**Thank you for wanting to become a member of SVCB.**

**For more information about SVCB and the great benefits of membership, please email membership@svcb.cc. In addition, use this address to request application forms in large print and braille.**

**TITLE: \_\_\_\_\_\_\_      NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STREET ADDRESS:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  STATE: \_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_**

**PRIMARY PHONE:                           ALTERNATE PHONE:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Can your information be published (Y/N)? \_\_\_\_\_\_\_\_\_\_\_\_**

**BIRTHDAY (MONTH; DAY; optional YEAR): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VISION STATUS: (LEGALLY BLIND, VISUALLY IMPAIRED, FULLY SIGHTED, PRINT HANDICAPPED) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PUBLICATIONS FORMAT: (BRAILLE, EMAIL, LARGE PRINT, CASSETTE)**

**SVCB IN TOUCH       BLIND CALIFORNIAN   BRAILLE FORUM**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEETING REMINDER:**

**Do you want to be contacted monthly about the next meeting and news items?:  \_\_\_\_\_\_\_\_\_\_\_\_**

**(Provide a phone number and/or email address as needed)**

**OTHER CCB CHAPTER MEMBERSHIP:**

**If you currently belong to any other chapter of the California Council of the Blind, give the chapter name:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MISCELLANEOUS: (OCCUPATION, SPECIAL INTERESTS, ORGANIZATIONS, etc.)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**