

## USICD MEMBERSHIP FORM

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United States International Council on Disabilities  
11 Hope Road, Suite 111, #254  
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**Date:** \_\_\_\_\_

**Membership Type:**     ☐ **Organizational (\$400)**

☐ **Individual (\$10)**

**Name of Organization:** \_\_\_\_\_

**First Name (Given Name):** \_\_\_\_\_

**Last Name (Surname):** \_\_\_\_\_

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

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State** \_\_\_\_\_

**Zip Code/Postal Code:** \_\_\_\_\_ **Country** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **(include country code)**

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

**Website:** \_\_\_\_\_

**Areas of Interest:** \_\_\_\_\_

*For more information, please contact:*

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