

Brain Injury Association of New Jersey, Inc.

INFORMATION AND RESOURCES DATABASE

Individual Registration Form

If you are an **individual practitioner**, please complete this three page application and forward with payment for professional membership to: BIANJ, 825 Georges Road., Second Floor, North Brunswick, NJ 08029.

Name of Professional: _____ Degree(s): _____

Contact Person: _____ Telephone: _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Fax #: _____ E-mail: _____ Website: _____

FEES:

Current Membership in BIANJ. Membership must be current to be included in database.

I am a current member of BIANJ. _____

Enroll me as a member of BIANJ (please complete membership application.) _____

Professional - \$50 Corporate (Incorporated or Professional)

\$ _____

PAYMENT:

_____ A check is enclosed payable to BIANJ.

_____ Please charge my credit card:

_____ Visa _____ Mastercard

Card # _____ Exp. Date _____

Signature _____

THANK YOU FOR YOUR SUPPORT!

Check one or two categories that best describe your area of expertise:

- | | | |
|--|--|--|
| <input type="checkbox"/> Attorney - Education | <input type="checkbox"/> Life Care Planner | <input type="checkbox"/> Optometrist |
| <input type="checkbox"/> Attorney - Personal Injury | <input type="checkbox"/> Medical Equipment Provider | <input type="checkbox"/> Orthopedist |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Medical Provider -Alternative specify field_____ | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Contractor/Rehab Engineer | <input type="checkbox"/> Neuro Ophthalmologist | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Counselor specify field_____ | <input type="checkbox"/> Neuropsychiatrist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Neuropsychologist | <input type="checkbox"/> Speech Pathologist |
| <input type="checkbox"/> Family Medicine/Internist | <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Therapeutic Rec. Therapist |
| <input type="checkbox"/> Learning Disability Consultant | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Vocational Rehab. Counselor |
| | <input type="checkbox"/> Ophthalmologist | <input type="checkbox"/> Other specify field_____ |

Type of Professional License: _____

Specialty areas of practice: _____

Board Certification(s) _____

Hospital Affiliations _____

What foreign languages do you speak? _____

Accepted Reimbursement Sources (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Private Health Insurance | <input type="checkbox"/> In-state Medicaid |
| <input type="checkbox"/> Automobile Personal Injury Protection | <input type="checkbox"/> Out-of-state Medicaid State _____ |
| <input type="checkbox"/> Workers Compensation | <input type="checkbox"/> TBI Medicaid Waiver |
| <input type="checkbox"/> Liability Insurance | <input type="checkbox"/> Self Pay |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Sliding Scale Fees |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Age Group Served ___All ___0-6yrs. ___7-12 yrs. ___13-21 yrs.
___22-66 yrs. ___65+ yrs.

Year Practice Established: _____

Do you serve as an expert witness? Yes _____ No _____

Is your office wheelchair accessible? _____

Please select the county your office is located in:

Northern region

- Bergen
- Essex
- Hudson
- Morris
- Passaic
- Sussex
- Union
- Warren

Central region

- Hunterdon
- Mercer
- Middlesex
- Monmouth
- Ocean
- Somerset

Southern region

- Atlantic
- Burlington
- Camden
- Cape May
- Cumberland
- Gloucester
- Salem

Please read the following statement and sign below:

The information on this application is truthful and complete. I understand that providing false or misleading information may be grounds for removal from BIANJ's Information and Resources Database. In addition, I will notify BIANJ if there are any changes in the information provided so that the Database can be updated.

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Please attach business card in this space:

BIANJ does not support, endorse, or recommend particular methods, treatments, or programs for people with brain injury. Our goal is to inform the public. We believe every individual affected by brain injury has the right to know what resources are available.



The Brain Injury Association of New Jersey, Inc. is a non-profit organization.



BIANJ MEMBERSHIP FORM

Date: _____

Name: _____

Telephone No. _____

Address: _____

Bus. Phone No. _____

Fax: _____

County: _____

E-mail: _____

Please Check:

- Person with Brain Injury
- Family Member: Relationship _____
- Professional: Field: _____
- Friend of BIANJ legislative network.

- I would like to receive BIANJ's **free** monthly E-News. **E-mail address is required.**
- I would like to join BIANJ's **free**

E-mail address is required.

Types of Membership:

- Individual: \$35.00**
- Professional: \$50.00**
- Corporate: \$200.00** (Includes two non-transferable staff memberships)
- Non-Profit Organization: \$200.00**
- Benefactor: \$200.00**

(1) Name & Title
(For Corporate Members)

(2) Name & Title
(For Corporate Members)

- Limited Income: \$5.00 - \$15.00** (for individuals with a brain injury or family members with limited resources)

- In addition to my membership, I would like to make a donation of \$_____.

- I work for a corporation that has a **Matching Gifts Program:**

Name & Address of Corporation _____

- I do not wish to renew but would like to make a donation of \$_____.

Please charge my credit card: Visa MasterCard

Card Number: _____ Exp. Date: ____/____/____

Name as it appears on the card: _____

Authorized Signature: _____ Today's Date: _____

Make checks payable to: Brain Injury Association of New Jersey (BIANJ)
Mailing Address: 1090 King George Post Road, Ste 708, Edison, New Jersey 08837

Thank you for your continued support.

