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

MEMBERSHIP FORM

Date: _____

Name: _____ Telephone No.: _____

Address: _____ Bus. Phone No.: _____

_____ Fax: _____

County: _____ E-mail: _____

☐ ***Please check box if this is a new address***

Please Check:

( ) Person with Brain Injury

( ) Family Member: Relationship: _____

( ) Professional: Field: _____

( ) Friend of BIANJ

Types of Membership*:

Membership benefits include access to resource materials and support groups, our monthly e-newsletter, an invitation to the Annual Seminar, advocacy updates and invitations to social events.

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

_____ _____

(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 do not wish to renew, but I would like to make a donation of $ _____

Please charge my credit card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

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

Name as it appears on the card: _____

Billing Address _____

(if different from address listed above): _____

Phone Number: _____

Authorized Signature: _____ Today's Date: _____ / _____ / _____

Make checks payable to: Brain Injury Alliance of New Jersey (BIANJ)

Mailing Address: 825 Georges Road, 2nd Floor, North Brunswick, NJ 08902

***Please allow 2-3 weeks for processing.**

Thank you for your continued support.