

Yes!

I want to become a member of the Wisconsin Direct Caregiver Alliance

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____ Cell: _____
E-Mail: _____
County: _____
Employer: _____

Membership Dues: Check all that apply

Direct Caregiver Member \$10 \$25
 \$50 \$100 other \$ _____

Affiliate Member \$10 \$25 \$50
 \$100 other \$ _____

An affiliate member is open to any individual or representative of an organization or entity that supports the mission of WIDCA. Affiliate members are non-voting members.

I would like to support the WIDCA by making an additional contribution of \$ _____ (indicate amount).

Please contact me about the ways I can get involved!

Please make your check payable to: WIDCA

Mail this completed form, with your check, to:

Wisconsin Direct Caregiver Alliance
600 Highland Avenue, Room H6/226
School of Nursing, UW-Madison
Madison, WI 53792-2455



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