CENTRAL OREGON
Disability Support Network

Membership Registration Form

Please enter your contact information for this event.
*=required field

Date: _____

My Role is: * ☐Parent/Family member ☐Professional ☐ Educator ☐Individual w/Disability

Organization (if applicable): *_____

Name: *_____Gender: ☐ M ☐ F ☐ Other

Street Address:*_____

City: *_____State: *_____Zip Code: *_____

County: *_____

Email: * _____

Phone number* ☐ Home ☐ Cell ☐ Work_____

Primary Language: _____
Language Support/Apoyo Lingüístico Request: ☐ Yes (Si) ☐No

School District: _____

My child is enrolled in the county developmental disability program (DD Services): ☐Yes ☐ No

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Demographic Information:
While the demographic information that you provide is voluntary, the funding sources that support CODSN's work request demographic data periodically. This information is anonymous.

Ethnicity

☐ African American/Black
☐ American Indian/ Alaskan Native
☐ Asian
☐ Caucasian/White
☐ Hawaiian/Pacific Islander
☐ Hispanic/Latino
☐ Multiracial
☐ Russian/East European
☐ Other

Year of birth of person with disability: _____

Child's Disability/Diagnosis: _____