



ASMT Membership Form

- I would like to **join** the ASMT
- I would like to **renew** my ASMT membership

Membership categories and fees:

- Adult with Autism (16 yrs. or older) Free
- Student Family \$10.00/yr.
- Professional \$25.00/yr.
- Agency (up to 3 subscribers) \$50.00/yr.

Date _____ Name _____

Spouse Name _____

Title _____

Agency (if applicable) _____

Address _____

City _____ State _____ Zip _____

County _____ Fax _____

Day Phone (____) _____ Night Phone (____) _____

E-mail _____ Spouse E-mail _____

Employer _____ Spouse Employer _____

- I would like to receive periodic email updates.
- I would like to volunteer – please call me.

To better serve our membership, please respond:

- For professionals: Educator Physician SLP OT Psychologist
- Other _____

For individuals/families (optional): Information about person with autism

First Name: _____ Last Name: _____
 Male Female Birth date ____/____/____ Diagnosis _____

How can ASMT better support you? _____

Payment: (Make check payable to: ASMT)
Membership Fee: \$ _____
Additional Contribution \$ _____
Amount Enclosed \$ _____

Mail membership form and payment to:

ASMT
955 Woodland Street
Nashville, TN 37206

Credit Card Information
(Credit Cards are also accepted over phone)
Card Type (Circle): Visa / MC
Card Number: _____
Name on Card: _____
Expiration Date: ____/____
Amount to charge card? \$ _____
Signature _____