



FEAT/RI
Families for Effective Autism Treatment
Membership Application

Date: _____ New Member: Renewal:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____

Relationship to Autism:

Parent: Relative: Professional: Other: _____

Childs Name (optional): _____ Birthday/Age: _____

Agency Affiliation/ABA Provider: _____

Please indicate any programs/ideas that you would like to see FEAT develop:

Yearly membership is (check one):

Parent/Family Member/Student/TA = \$35

Professional Individual = \$50

Professional Agency Group = \$150

Send to:

FEAT/RI
P.O. Box 8460
Cranston, RI 02920