Yes, I want to join the Sight-Loss Support Group of Central PA, Inc.!

Title ____ Name_____ Business/Org_____

Address_____City_____

State_____Zip_____Phone_(____) _____E-mail_____

Please send my SLSG newsletter via: ☐ Mail ☐ E-mail ☐ Please do not send.

☐ **I have sight loss.** ☐ **I have a friend/family member with sight loss.** ☐ **I am a sight-loss advocate!**

Annual Membership Dues: ☐ Individual $15 ☐ Family* $20 ☐ Organization/Business $50

☐ Senior (55+) $10 ☐ Student/Fixed Income $10 ☐ Additional Donation $_____

☐ **I would like to volunteer with SLSG.** Please call me within this time-frame: _____

Please make check payable to the *Sight-Loss Support Group, Inc.* and mail with this card to:

Sight-Loss Support Group, P.O. Box 782, Lemont, PA 16851

Thank you for your support. We look forward to meeting you soon!

*Please list family members' names on the back of this card and circle the names of those with sight loss.