



SUPPORT ORGANIZATION MEMBER APPLICATION

To be considered for Support Organization Membership, an organization must fully complete this Application and submit all of the information requested with respect to the checklist below. If you have any questions regarding your business’s eligibility for Support Organization Membership or regarding this Application please contact us at info@disabilitychamber.org.

To qualify for Support Organization Membership, your organization must be determined to be a Support Organization. That determination is made by the Chamber’s Board of Directors (or the membership committee, if such a committee has been appointed), in its sole discretion. The following definition of Support Organization is in accordance with the Chamber’s Bylaws:

“Support Organization” means a business or other organization that, as part of its operations, provides a significant benefit to the disability community (e.g., purchase a significant amount of the organization’s services and products from Disability Businesses, have a track record of employment of the disabled, provide significant grants to the disabled).

Once an organization is determined to qualify as a Support Organization, such organization shall become a Support Organization Member upon the payment of the applicable membership fee. The membership fees are as follows:

Level of Membership	1 Year	2 Years	5 Years	Lines of Text Posted on Chamber Website*
Platinum	\$5,000	\$9,500	\$20,000	20
Gold	\$1,000	\$1,850	\$4,000	10
Silver	\$500	\$925	\$2,000	5
Contributor	\$250	\$450	\$1,000	-

* The Chamber will post the name, address, phone number, fax number, and e-mail address for each Support Organization Member.



GENERAL INFORMATION

If, at any time, the Chamber has reason to believe that any person or business has willfully and knowingly provided incorrect information or made false statements, or acted in a manner prohibited by applicable law, the Chamber shall refer the matter to the appropriate agency.

1. Name of organization: _____
2. Address of organization (mailing and street): _____

3. Phone number & fax number of business: _____
4. E-mail address and website: _____
5. Contact person: _____
6. Primary designated representative: _____
7. Number of employees: _____
8. Nature of significant benefit provided to the disability community:

9. Geographical area in which the organization provides significant benefit to the disability community:
States: _____ Counties: _____
10. Years that such significant benefit has been provided: _____
11. How did you hear about the Chamber: _____
12. Type/Duration of Membership: _____
13. Method by which membership fee will be paid: _____
14. If by credit card, please provide the credit card number and expiration date:



In case your business is determined to be a Support Organization Member, please provide the text that you would like to be included on the Chamber's website under your business's name. The lines of text that will be posted will be based on the level of membership as provided on page 1 of this Application. Also please provide any website link you would like included under your business's name.



(Please attach checklist to application with the appropriate boxes marked)

- Submit verifiable evidence of significant benefit to the disability community (e.g., evidence of a track record of involvement in the ABLE Trust or the Business Leadership Network).
- Write "N/A" (Not Applicable) if it applies to any section.

Please mail all forms to:

**Chamber of Commerce for Persons with Disabilities, Inc.
6932 Sylvan Woods Drive
Sanford, FL 32771
(407) 650-0926 Facsimile
info@disabilitychamber.org**



AFFIDAVIT

The undersigned swears that the foregoing statements are true and correct and include all material information necessary to identify and explain the operations of

_____, as well as the ownership thereof. Further, the undersigned agrees to permit the audit and examination of books, records and files of the named business. Any material misrepresentation will be grounds for terminating membership and for initiating action under Federal and State laws concerning false statements.

Note: If, after filing this Application, there is any significant change in the information submitted, you must promptly inform the Chamber of the change.

Signature: _____

Name (print or type): _____

Title: _____

Date: _____

State of: _____

County of: _____

On this _____ day of _____, 20____, before me appeared (name) _____, to me personally know, who, being duly sworn, did execute the foregoing affidavit, and did state that he or she was properly authorized by (name of business) _____, to execute the affidavit and did so as his or her free act and deed.

Seal:

Notary Public: _____

Commission Expires: _____