



We thank you for supporting the work of the New York Workers' Compensation Alliance!

Please complete this form and submit with payment.

Name: _____

Firm Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ Phone: _____

MEMBERSHIP CONTRIBUTION LEVELS

___ **DIRECTOR** \$3,000/year OR \$250/month with 12-month commitment
Contributions may be paid annually, quarterly or monthly. Director status is subject to the approval of the WCA Board of Directors.

___ **SPONSOR** \$2,400/year OR \$200/month with 12-month commitment
Includes recognition on the WCA website + link to firm website.

___ **SUPPORTER** \$1,500/year OR \$125/month with 12-month commitment
Includes recognition on the WCA website.

___ **MEMBER** \$900/year OR \$75/month with 12-month commitment

PAYMENT INFORMATION

AMOUNT: \$ _____

___ Check Enclosed (Please make payable to: NYWCA)

___ Credit Card: ___ Visa ___ MasterCard ___ Amex ___ Discover

Name on Card: _____

Card Number: _____

Expiration Date: _____ Security #: _____

Return completed form with payment to:

NYWCA, 230 Washington Avenue Extension, Suite 101, Albany, NY 12203

or fax to: 518-463-8656 **or** make complete this form online at: www.nyworkerscompensationalliance.org.