

LICoP Membership Form

Parent's Name: _____

Child's Name: _____

Phone: _____

E-Mail: _____

Cell Phone: _____

Address: _____

I have a child with special needs in the area(s) of:

Grade: _____

Age: _____

Tax Deductible Donation:

\$10.00 \$20.00 \$50.00 \$100.00 Other Amount \$_____

Please MAil this form to:

Mail To:

Long Island Communities of Practice

P.O. Box 5013

Montauk, NY 11954

We Look Forward to Hearing From You!