



Fifth Freedom Membership Application

I want to join the Fifth Freedom Network:

Name: _____

Address: _____

City/State/Zip: _____

County: _____

Telephone (day): _____

Telephone (night): _____

E-Mail: _____

Fax #: _____

**Please return this form by
mail or fax to:**

**Fifth Freedom
227 East Washington Blvd. Suite 304
Fort Wayne, IN 46802**

**Voice: (260) 426-8789
Fax: (260) 426-8790
E-mail: info@fifthfreedom.org**

____ Check here if you are interested in becoming an ACT Team Leader and we will contact you.

I am: ____ person with a disability ____ family member ____ other advocate

____ Check here if you are interested in becoming an ACT Team Leader and we will contact you.

Please check the topic or topics you are most interested in:

____ Accessible Housing ____ Advocacy ____ Employment ____ Health Care

____ Special Education ____ Transportation Other _____

Do you have home access to a computer with Internet Service? ____ Yes ____ No

Please briefly describe the advocacy activities, training or experience that you have had.

Signature: _____ Date: _____

Please describe the disability accommodations you will require to receive information.
