



ICAN

Advisory Council

Membership Application

Name:	
Organization:	
Position/Title:	
Address:	
City:	
State:	
Zip:	
Phone: (home)	
Phone: (work)	
Email address:	
Highest level of Education:	
Age:	
Race:	
Gender:	

User of Assistive Technology:

Individual/Applicant:
Particular Disability:

Family Member:
Please Specify: (ex: Spouse, Child, etc.)

Community Service:

Membership Representation:

- Individual with disability that uses assistive technology.
- Family Member/Guardian of an individual with a disability that uses assistive technology.
- Representative of Vocational Rehabilitation.
- Representative of Centers for Independent Living.
- Representative of State Services for the Blind.
- Representative of State Workforce Reinvestment Board.
- Representative of Arkansas Department of Education.
- Representative of Department of Employment and Economic Development.
- Representative of Public Relations.
- Other: _____

**Please any specific area of expertise you have to offer the advisory council:
(ex: Special Ed. Teacher, Therapist, Parent, Disability Advocate, ect.)**

Signature

Date

Fax to ICAN: 1-501-666-5319