



MEMBERSHIP APPLICATION

Organization: _____

Address: _____

Phone: _____ Email: _____

Website: _____

501(c)3 Yes No Nonprofit EIN# _____

Is your organization a member of the National VOAD? Yes No

If so, what member organization? _____

VOAD Representative: _____

Phone: _____ Email: _____

Alternate Representative: _____

Phone: _____ Email: _____

Organization's Mission:

Disaster Phases (Please circle all that apply to your organization)

Preparation Response Recovery Mass Care

My organization is statewide regional county local/city in scope (check all that apply).

Disaster Services Provided (If needed, attach a separate sheet for more detail.)

(Please attach a copy of your organization's Disaster Services Plan.)

My organization will be involved in the following committees (check all that apply).

- | | | |
|---|---|--|
| <input type="checkbox"/> Advocacy | <input type="checkbox"/> Disaster Case Management | <input type="checkbox"/> Long-term Recovery Groups |
| <input type="checkbox"/> Communications | <input type="checkbox"/> Disaster Health | <input type="checkbox"/> Mass Care |
| <input type="checkbox"/> Community Preparedness | <input type="checkbox"/> Emotional Spiritual Care | <input type="checkbox"/> Volunteer Management |
| <input type="checkbox"/> Donations Management | <input type="checkbox"/> Housing | |