NCDDD

NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS www.ncddd.org

FY2024 NCDDD MEMBERSHIP FORM

Name: _____

Title: _____

Agency: _____

Mailing Address: _____

City/State/Zip: _____

Email Address: _____

MEMBERSHIP TYPE:

☐ Director ($50.00) ☐ Associate ($15.00)

PAYMENT:

Method of payment: ☐ PayPal ☐ Personal Check* ☐ Agency Check*

Submit checks payable to **"National Council of Disability Determination Directors (NCDDD)"**

Name on Agency Check: _____

Check Number: _____ **Date of Check:** _____

Mail completed form with check to:

Disability Determination Services
Attn: Frank Gilbertson
121 7th Pl E.
Suite 300
St. Paul, MN 55101

DEDICATED TO IMPROVING THE SOCIAL SECURITY DISABILITY PROGRAM