ALLIANCE FOR
WOMEN IN MEDIA
NEW YORK STATE CAPITAL DISTRICT AFFILIATE

MEMBERSHIP APPLICATION

(Please complete this form to join the NYS CAPITAL DISTRICT AFFILIATE)

I. PERSONAL INFORMATION *(please type or print clearly)*

Name____

Title____

Company/Organization________________________________

Address____

City___________________________State_________Zip___________

Phone__________________________Fax________________

Email____

III. MEMBERSHIP CLASSIFICATION

(Please select one in each section)

Select one:

❏ Professional Member $25

❏ Student $0

IV. PAYMENT INFORMATION

Total amount enclosed $___________________

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Signature

I hereby certify that the completed information above it true and correct, and I understand that this membership is personal to me and is NOT REFUNDABLE. I also understand that my membership is for one full year.

Please return completed application to:

CAPITAL DISTRICT CHAPTER
ALLIANCE FOR WOMEN IN MEDIA
P.O. BOX 5043
ALBANY, NY 12205

CHECK ONLY PAYMENTS

II. OTHER INFORMATION

(optional)

Please check the media that you work for:

❏ Radio ❏ Television

❏ Cable ❏ Print

❏ New Media

Please check the ONE category that best describes your job responsibility:

❏ Administration
❏ Advertising
❏ Broker
❏ Business/Finance
❏ Community Affairs
❏ Consulting
❏ Creative
❏ Education
❏ Engineering
❏ Executive Search
❏ Government
❏ Graphics/Design
❏ HR/Personnel
❏ Law
❏ Management
❏ Media Services
❏ Operations
❏ Ownership
❏ Production
❏ Programming
❏ Public Relations
❏ Publishing
❏ Research
❏ Sales/Marketing/Promotion
❏ Student
❏ Talent/News
❏ Traffic
❏ Other ____________________