



Please type in the fields below while online, then print out and mail or fax the completed form to the address shown at the bottom.

**I. PERSONAL INFORMATION**

Last Name	First Name	Middle Name	Application Number (for internal use only) <b>W</b> _____
Present Address - No. and Street		City	State
Zip Code			
Permanent Address (if different from above)			
Daytime Phone ( ) - ext. _____	Evening Phone ( ) - _____	Cell Phone (optional) ( ) - _____	
E-mail: _____	Birth Date: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	

**II. CLASSIFICATION OF DISABILITY**  
Please fill out below only the section (A, B, or C) that corresponds to your primary disability

**A. Traumatic spinal cord injury:** Date of Injury: \_\_\_\_\_

Level of Injury:  C01-C08 Cervical  T01-T12 Thoracic  L01-L05 Lumbar  S01-S05 Sacral

Cause of Injury:

Vehicular (auto, motorcycle, aircraft, bicycle, etc.)  Sports or Recreation (swimming, diving, etc.)

Violence (gunshot, stabbing, explosion, etc.)  Falls  Other traumatic injury

**B. Congenital spinal disorder:**

Spina Bifida  Diastematomyelia  Tethered spinal cord syndrome

Werdnig – Hoffman Disease  Other (specify): \_\_\_\_\_

**C. Spinal cord disease:**

Specific disease: \_\_\_\_\_ Date of diagnosis / onset of condition: \_\_\_\_\_

Multiple Sclerosis  Syringomyelia

Poliomyelitis  Other (specify): \_\_\_\_\_

Amyotrophic diseases (lateral sclerosis, transverse myelitis, etc.)

**III. LEVEL OF FUNCTION**

**Indicate your level of function:**

Paraplegia  Quadriplegia  Hemiplegia  No paralysis at this time

**IV. VETERAN STATUS**

**Are you a U.S. Military Veteran?**  Yes  No

Branch of service:  Army  Air Force  Navy  Marine Corps  Coast Guard Other: \_\_\_\_\_

Is your spinal cord injury or disease service connected?  Yes  No

**I hereby declare that my statements on this application are true and correct to the best of my knowledge.**

Applicant's signature\*: \_\_\_\_\_ Date \_\_\_\_\_

Please fax completed applications to 718 803-0414, or mail to:  
Attn: Membership Department  
United Spinal Association  
75-20 Astoria Blvd.  
Jackson Heights, NY 11370-1177

**\*Note:** If the applicant is under the age of 13, this application must be signed by a parent or guardian

\_\_\_\_\_  
Name of Parent or Guardian

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date