VOICES, Inc. 7900-20 103rd Street, Suite 16 Jacksonville, FL 32210

Please enclose a check or money order for the $5 annual membership fee. Mail to address above.

A waiver may be applied for those who cannot afford it. Check here if fee is enclosed. ☐

This membership is for an injured worker ☐, a non-injured person ☐, a business or organization ☐

Name	Street Address	
City	State	Zip
Occupation	Home phone with area code	
Alternate phone with area code	Mobile/cell phone with area code	
Fax number with area code	Email address	
Business/organizations only: Name	Business address and phone	

Injured workers only:

Date of birth	Date of injury	Severity of Injury Mild ☐ Moderate ☐ Serious ☐
Type of Injury (diagnosis if known)		

Optional information for injured workers:	Date benefits began
Are you totally disabled?	Are you on SSD?
Do you have an attorney?	Attorney's name
Employer when injured	Employer's w/c insurance carrier

How has workers comp treated you? Give as much detail as you can. Include treatment by your doctor(s), attorney, delays, denials, obstructions, etc. Please attach another sheet of paper, as you will probably need more space.

PLEASE be sure to fill out the ENTIRE form

Your signature below indicates that you agree to provide assistance, support and advocacy for injured workers, to work to further the cause of VOICES, Inc.., to help educate others about the need for VOICES, Inc. as well as its purposes and its goals, to work to further its goal of providing comfort to and education for injured workers and to advocate for reform of the Workers Compensation system.

Signature (required) _____ Date _____

Mary Bailey
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Online application is available at http://www.voicesflorida.bravehost.com/onlineapp.html