GOBDF
GREATER OHIO
BLEEDING DISORDERS
FOUNDATION

BECOME A MEMBER!

Please include everyone who is immediate family living in the same household. Immediate family is defined as EITHER patient, parents and minor siblings OR patient, partner and minor children. Please do not include cousins, adult siblings, grandparents, etc.

Scan me and complete from your phone.

Last Name:_____ First Name:_____

Address:_____

City:_____ State:_____ Zip:_____County:_____

Email: _____ Preferred Phone:_____

Household members **WITH** a bleeding disorder.

Name	Date of Birth	Gender	Bleeding Disorder

Household members **WITHOUT** a bleeding disorder:

Name	Date of Birth	Gender	Relationship

*If you wish to receive all invitations to community programs and events, please provide your email address.
Not all chapter materials will be sent by USPS.

ADDITIONAL INFORMATION ON REVERSE

AUTHORIZATIONS (Optional)

__ I give my HTC or treating hospital permission to confirm my/my family members' bleeding disorder diagnosis with chapter staff. ***This is required to receive services and attend programs.***

Patient Name	Date of Birth	Hemophilia Treatment Center / Treating Physician

__ I give permission for the chapter to use me/my family in photos and/or videos to be used in chapter marketing materials and publications.

__ I wish to be placed on the mailing list to receive invitations to programs, service offerings and community updates. You may opt out at any time.

__ I am interested in learning more / participating in advocacy outreach:

- __ Calling or visiting Legislators
- __ Writing Legislators

Anything else you'd like to share with the chapter?

_____

_____

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Please send your completed form to the address or fax below or email to tracy@gobdf.org