THE NORTHERN OHIO HEMOPHILIA FOUNDATION INC.

ANNUAL MEMBERSHIP FORM

Please mail your completed application to:
Northern Ohio Hemophilia Foundation, Inc. 5000 Rockside Rd., Suite #230 Independence, OH 44131

Name:_____ E-mail address:_____

Address:_____ City: _____

Zip: _____ County: _____ Home Phone: :_____ Cell Phone:_____

All family members living in your household:

Name and Relationship to Person with BD	Gender	Date of Birth	Type of BD (Bleeding Disorder): (Hemophilia A, B, VWD, Other, None)

Does anyone in your household have an inhibitor? YES NO

Do we have your permission to confirm your diagnosis with your treating physician? YES NO

Who is your treating physician/HTC? _____

I approve use of photographs of me/my family in NOHF publications YES NO

Membership is FREE, but please consider making a tax-deductible donation to our Emergency Assistance Fund to support a family in need.

____$25 ____$50 ____$100 ____$250 ____$500 ____Other