



HBDA Annual Membership Form

**This information is for Chapter use only;
it will not be distributed or shared.**

PLEASE PRINT ALL INFORMATION (one form per address)

Name: _____ Affected Yes ___ No ___ Hemophilia A ___ B ___ VWD ___

Birth Date: (mm/dd/yyyy) _____

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Name: _____ Affected Yes ___ No ___ Hemophilia A ___ B ___ VWD ___

Birth Date: (mm/dd/yyyy) _____

Address: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Primary Contact Email Address _____

Please identify your relationship to the bleeding disorders community:

- I have a bleeding disorder
- I have a child with a bleeding disorder
- I have another family member with a bleeding disorder
- I work for a Home Care Company
- I work for a Pharmaceutical Company
- Other-

As a member of HBDA, you will be included in, and authorize the following:

- Receive invitations to members only events and functions (such as Family Camp programs)
- Receive invitations to educational events sponsored by Pharmaceutical Companies and Home Health Companies
- Receive the HBDA Newsletter
- Receive e-mail notifications from HBDA
- Birthday recognition in the HBDA Newsletter
- Participation as volunteer on committees (contact HBDA)
- Opportunity to apply for scholarship funds or new programs (based on eligibility)
- I give permission for myself and my family members to be photographed and/or videotaped at HBDA events and to be shared and/or reprinted by representatives of HBDA for the HBDA website, the HBDA Newsletter or other HBDA correspondence as deemed appropriate by these representatives.

Signature

Date