



## HBDA Registration Form

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

**PLEASE PRINT ALL INFORMATION (one form per address)**

**Family Name:** \_\_\_\_\_

**Name:** \_\_\_\_\_ Affected Yes \_\_\_ No \_\_\_ Hemophilia A \_\_\_ B \_\_\_ VWD \_\_\_

**Birth Date: (mm/dd/yyyy)** \_\_\_\_\_

**Name:** \_\_\_\_\_ Affected Yes \_\_\_ No \_\_\_ Hemophilia A \_\_\_ B \_\_\_ VWD \_\_\_

**Birth Date: (mm/dd/yyyy)** \_\_\_\_\_

**Name:** \_\_\_\_\_ Affected Yes \_\_\_ No \_\_\_ Hemophilia A \_\_\_ B \_\_\_ VWD \_\_\_

**Birth Date: (mm/dd/yyyy)** \_\_\_\_\_

**Name:** \_\_\_\_\_ Affected Yes \_\_\_ No \_\_\_ Hemophilia A \_\_\_ B \_\_\_ VWD \_\_\_

**Birth Date: (mm/dd/yyyy)** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

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 \_\_\_\_\_

**Please check all below that apply to your interests:**

- I would like to receive invitations to educational events sponsored by Pharmaceutical Companies and Home Health Companies.
- I would like to receive the HBDA Newsletter
- I would like to receive e-mail notifications from HBDA
- I want my Birthday recognized in the HBDA Newsletter
- I would like to become an active volunteer on a committee

**Please tell us the things you would like to see HBDA offer:** \_\_\_\_\_

**Continue on reverse side if necessary**