OANY OSTOMY ASSOCIATION OF NEW YORK INC

We are an affiliated support group of the United Ostomy Associations of America

MEMBERSHIP APPLICATION
Welcome to the Ostomy Association of New York, a 501(c)(3) nonprofit, volunteer organization. As a member, you have access to all services offered by the association including regular meetings, mutual support and advocacy, our newsletter (digital or print) and website plus all association-generated mailings and information.

The information you provide will be kept confidential and be used solely by the association to facilitate networking/mutual support and provision of services for you. No identifying information will ever be released for any reason without your expressed written consent.

Name: ____ Date: _____________________

Address: ____

City: _______________________ State: _________________ Zip: ______________________

Home Phone: ________________ Bus. Phone: ________________ Cell Phone: _____________

E-mail: ____ Birth Year: _______

Procedure and Relationship (Please check all that apply)

[ ] Colostomy
[ ] Ileostomy
[ ] Urostomy (Ileal Conduit)
[ ] Continent Urostomy (e.g., Indiana pouch)

[ ] Continent ileostomy
[ ] J-Pouch/Pull Through
[ ] Neo-Bladder
[ ] Other:_____________
____

[ ] Self
[ ] Parent of child w/ procedure
[ ] Spouse/Family/Significant other
[ ] Physician
[ ] Nurse
[ ] Social worker

[ ] Temporary, Anticipated Time Period: _____________

Surgery date(s):___________________________________

Reason for surgery:
[ ] Cancer [ ] Crohn's Disease [ ] Ulcerative Colitis [ ] Birth Anomaly

[ ] Other (please explain): ____

____

Occupation (Current or Prior): ____

Avocation/Interests/Hobbies: ____

____

Language(s) spoken:____

Please continue on the reverse side of this page

Please indicate (✓) if you have knowledge of ______; experience with ______; interest in______ helping out in any of the following areas:

COMPUTER SKILLS:
Databases _____; Desktop Publishing (e.g., pamphlets, newsletters) _____; Accounting _____;

Other (Explain): ____

PUBLICITY:

___Identify/pursue opportunities to disseminate information about OANY and OANY meetings via local newspapers, cable TV, community events, etc.

___Distribute information to local pharmacies, hospitals, other facilities.

___Identify and develop relationships with various health providers (e.g., nurses, social workers, discharge planners) who interact with individuals with ostomies.

___**MEET AND GREET:** Greet individuals attending meetings and identify and direct newcomers to appropriate resource persons within the association.

___**VISITOR TRAINING:** If you are interested in, or wish more information about becoming trained to provide information and mutual support to other ostomates via in-person and/or telephone/e-mail contacts, please notify Diane Watkin by leaving a message at 212-864-1968.

___**OTHER:** Please let us know how ***you*** would like to be helpful!

ANNUAL MEMBERSHIP FEE (January 1 through December 31)………………………… $25.00

Please submit your application and/or payment (payable to Ostomy Association of New York) by one of the following methods:

1) Mail application and/or payment (check or money order, no cash please) to the below OANY address;

2) Email your application to (*diane@oanewyork.org*) and submit your payment via PayPal or credit/debit card on our website at: *www.oanewyork.org/membership*;

3) You can also hand deliver both application and payment (check, money order or cash) to any of our scheduled meetings during the year. Ask for our treasurer, Gail Jasne, at the meeting. Go to: *www.oanewyork.org/events* for dates of our scheduled meetings. Future meeting dates are also noted on page one of our newsletter.

☐ **CHECK BOX FOR EMAIL DELIVERY OF YOUR NEWSLETTER.**

OANY
c/o Gail Jasne
P.O. Box 187, Gedney Station
White Plains, NY 10605

Thank you very much and welcome to the Ostomy Association of New York