ANNUAL MEMBERSHIP FORM

Please mail your completed application to:
Northern Ohio Hemophilia Foundation, Inc.   17407 Lorain Ave, Suite #206   Cleveland, OH 44111

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)

☐ I am the parent of an adult child with a bleeding disorder (legacy member). May not be eligible for all membership benefits.

☐ I don't have a bleeding disorder but want to support the community. May not be eligible for all membership benefits.

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   N/A

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