OANY

Comprising the Colostomy Society of New York, Inc. & the Ileostomy Association of New York, Inc.
(Affiliated Support Groups of the United Ostomy Associations of America)

MEMBERSHIP APPLICATION

Welcome to the Ostomy Association of New York. 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 all association-generated mailings and information.

The following information will be kept confidential and be used solely by the association to facilitate networking/mutual support and provision of services. 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: _____

Year of surgery:_____

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

_____

Occupation (Current or Prior):_____

Avocation/Interests/Hobbies:_____

_____

Language(s) spoken (e.g., Spanish): _____

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 _____;

ther (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 DUES ARE $25.00
Individuals with **ileostomies (temporary or permanent), Kock pouches, "J pouches" and urinary diversions** make payment to: **Ileostomy Association of New York, Inc. (IANY)**

Individuals with **colostomies** make payment to: **Colostomy Society of New York, Inc. (CSNY)**

Please send your completed application form with a check or money order (please, no cash) to:

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

CSNY
c/o Marge Scannell
P.O. Box 1195, Riverdale Station
Bronx, NY 10471

Payment can also be made via PayPal on our website: *www.oanewyork.org/membership* or can be hand delivered at any of our scheduled meetings during the year. Go to: www.oanewyork.org/events for our meeting schedule.

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