



Member Registration

1 Primary Contact Information (This is the person to whom mail will be addressed.)

Title: Mr. Mrs. Ms. Dr.

First Name: _____ Last Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

County: _____ School District: _____

This is a: Home Address Business Address

Home Phone: _____

Cell Phone (Optional): _____

Work or Other Phone (Optional): _____

What is the best time to reach you? Morning Afternoon Evening Anytime

E-Mail Address: _____

2 Communication Preference

How do you prefer to receive communications and invitations? U.S. Mail E-mail Both

Note: If you have indicated e-mail, be sure to enter an e-mail address in the space provided above.

3 Member Information

Please complete the information on the following pages for **each person** living in your household. For individuals that do not have a bleeding disorder, select the option "None" and indicate the relation to the person with the bleeding disorder.

Why do we ask for this information? We offer specific programs that are based on type of bleeding disorder, gender, and/or age of the affected person and/or immediate family members. In addition, we have special mailings that include literature that is targeted towards specific bleeding disorders

First Name	Last Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Bleeding Disorder <input type="checkbox"/> Hemophilia A (Factor VIII deficiency) <input type="checkbox"/> Hemophilia B (Factor IX deficiency) <input type="checkbox"/> von Willebrand Disease <input type="radio"/> Type 1, <input type="radio"/> Type 2, <input type="radio"/> Type 3 <input type="checkbox"/> Thrombophilia <input type="checkbox"/> Other _____ <input type="checkbox"/> None –Indicate relationship to person with bleeding disorder (circle one) Spouse Parent Child Sibling Other _____		Severity <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Inhibitor <input type="checkbox"/> Tolerized <input type="checkbox"/> Not Tolerized <input type="checkbox"/> N/A
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Volunteer Opportunities

If you would like to be a chapter volunteer and donate your time or services, please indicate your interests below.

- Advocacy
- Board Member *(you will be contacted by a current member of the Board of Directors)*
- Childcare at Events or Meetings *(background check may be required)*
- Committee Volunteer
- Event Volunteer
- General Office Tasks *(our office is on the 2nd floor, there's no elevator)*
- Professional Services (i.e., IT Support, Computer Repair, Graphic Design, Photography, Printing, Editing, etc.)
(please explain) _____

- Other Talents or Skills (i.e., Musician, D.J. Services, Face Painting, Balloon Designs, Crafts, etc.)
(please explain) _____

Thank you for completing this registration form.

You may return the form to us in any of the following ways:

E-mail: Scan and e-mail your completed form to: info@westpennhemophilia.org

Fax: Our fax number is: **724-741-6167**

U.S. Mail: Our address is: **WPCNHF
20411 RT 19, Unit 14
Cranberry Township, PA 16066**