THE NORTHERN OHIO HEMOPHILIA FOUNDATION INC.

ANNUAL MEMBERSHIP FORM

Please mail your completed application with the appropriate fee to:
Northern Ohio Hemophilia Foundation, Inc. 5000 Rockside Rd., Suite #230 Independence, OH 44131

Name:_____ E-mail address:_____

Address:_____ City: _____

Zip: _____ County: _____ Home Phone: :_____ Cell Phone:_____

Family members living in your household:

Name	Date of Birth*	Type of Bleeding Disorder: (Hemophilia A, B, VWD, Other, None)

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

Who is your treating physician/HTC? _____

I approve use of photographs of me/my family in NOHF publications YES NO

Membership Levels:

____$0 Complimentary Membership: Person or family with bleeding disorder and financial hardship

____$15 Single Membership: Individual with a bleeding disorder

____$25 Family Membership: Immediate family / person with a bleeding disorder

____$ Additional donation