NATIONAL HYDROCEPHALUS FOUNDATION MEMBERSHIP FORM

Name: ____

Address:____

City: ______________________________State:____________________ Zip Code:___________

Phone: ________________________ E-Mail: ____

___ Yes, I want to become a member of the National Hydrocephalus Foundation. I understand the annual membership fee is $40.

___ I like to make a tax-deductible donation of $______

Method of Payment:

___ Check: Total Amount $_______
___ Credit Card: ___ Visa___ Master Card

Account Number:______________________________________

Name of Card Holder:____________________________________

Signature:____

Verification Code: __________
(last set of numbers on back of card)

Expiration Date:____________

Total Amount:_____________

___ I would like to be a parent-to-parent and/or adult-to-adult referral (Circle one)

Please provide some information about the individual with hydrocephalus:

Name of Person with hydrocephalus: ____

Type of hydrocephalus: ____

Age when diagnosed: ________ Current Age: __________

Other information you would like to provide and/or medical conditions:

____

____

____

I hereby give my permission to have my contact information given to another individual and/or family in which I might be able to assist.

__________________________________ ____________________
SIGNATURE DATE

MAIL TO:

NATIONAL HYDROCEPHALUS FOUNDATION
12413 CENTRALIA ROAD LAKEWOOD, CA 90715-1623

Phone: 562-924-6666 888-857-3434
Federal Tax I.D.: 36-3218744