



# Member Information

## 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: \_\_\_\_\_

Home/Landline Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work or Other Phone (Optional) - please specify landline or cell: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

## COMMUNICATION PREFERENCE

How do you *prefer* to receive communications? (select all that apply)  U.S. Mail  E-mail\*  Text\*

Please know, if you *only* select E-mail and/or Text, you will still remain on our regular mailing list; however, most invitations and notices will be sent to you via e-mail and/or text, instead of U.S. Mail.

\*If you have indicated e-mail and/or text, be sure to provide an e-mail address and/or cell phone number, above.

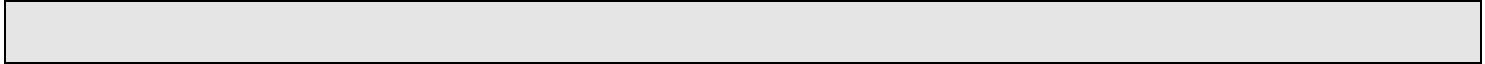
## MEDICAL INFORMATION

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 their relation to the person with the bleeding disorder. (Feel free to request or make additional copies, if needed.)

**Why do we ask for this information?** We offer specific programs and social/networking events that are based on type of bleeding disorder, gender, and/or age of the affected person or immediate family members. In addition, we send informational mailings with materials that may be targeted toward a specific bleeding disorder, age group, etc. We can use this information to filter our mailing list and only send the information to the pertinent households. This helps save the chapter money and also helps reduce the amount of irrelevant mail you receive.

|                   |                  |                      |   |
|-------------------|------------------|----------------------|---|
| <b>First Name</b> | <b>Last Name</b> | <b>Date of Birth</b> | <b>Gender</b><br><input type="checkbox"/> Male <input type="checkbox"/> Female<br><input type="checkbox"/> _____<br><input type="checkbox"/> Prefer not to answer |
|-------------------|------------------|----------------------|---|

|   |  |   |   |
|---|--|---|---|
| <b>Bleeding Disorder</b><br><input type="checkbox"/> Hemophilia A (Factor VIII Deficiency) <input type="checkbox"/> Hemophilia B (Factor IX Deficiency)<br><input type="checkbox"/> Hemophilia A Carrier <input type="checkbox"/> Hemophilia B Carrier<br><input type="checkbox"/> Factor V Deficiency <input type="checkbox"/> Factor VII Deficiency<br><input type="checkbox"/> Factor X Deficiency <input type="checkbox"/> Factor XI Deficiency<br><br><input type="checkbox"/> von Willebrand Disease: <input type="radio"/> Type 1, <input type="radio"/> Type 2 ( <input type="checkbox"/> 2A, <input type="checkbox"/> 2B, <input type="checkbox"/> 2M, <input type="checkbox"/> 2N), <input type="radio"/> Type 3<br><br><input type="checkbox"/> Other _____<br><br><input type="checkbox"/> None –Indicate relationship to person with bleeding disorder (circle one)<br>Spouse   Parent  Child   Sibling   Other _____<br><br><input type="checkbox"/> None –Surviving family member of a person with a bleeding disorder |  | <b>Severity (if known)</b><br><input type="checkbox"/> Mild<br><input type="checkbox"/> Moderate<br><input type="checkbox"/> Severe | <b>Inhibitor History</b><br><input type="checkbox"/> Yes, Tolerized<br><input type="checkbox"/> Yes, Not Tolerized<br><input type="checkbox"/> No Inhibitor |
|---|--|---|---|

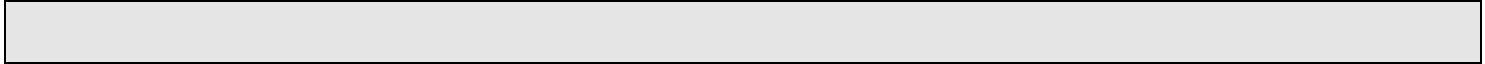


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**PHOTO/VIDEO RELEASE**

At the Western Pennsylvania Chapter of the National Hemophilia Foundation (WPCNHF), we like to take pictures and/or video of our activities to illustrate and promote Chapter events. We use these images for purposes such as brochures, newsletters, flyers, invitations, website, social media, proposals, etc. Your name will never be used in conjunction with any photo, without prior consent. WPCNHF requests your permission to use photos or video of you/your family, for the purposes stated above. This agreement will remain in effect until you notify us in writing.

No, I do not want WPCNHF to use photos/video of me/my family.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Yes, WPCNHF has permission to use photos/video of me and any minor children living in my household or attending events with me, for purposes stated above in this agreement. **Please provide the names & signatures of household members ages 18 and over (including the person completing this form):**

Full Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Full Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Full Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Full Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**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)*
- Educational Event Volunteer
- Fundraising 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**COMMENTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thank you for completing this form. You may return it any of the following ways:**

E-mail: [info@wpcnhf.org](mailto:info@wpcnhf.org) | FAX: 724-741-6167 | U.S. Mail: WPCNHF, 20411 Route 19, Unit 14, Cranberry Township, PA 16066