PATIENT MEMBERSHIP FORM

MEMBER INFORMATION How did you hear about us?_____ Today's Date: _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt/Suite: _____

City: _____ State/Province: _____

Zip/Postal Code: _____ Country: _____ Phone: _____

Fax: _____ E-mail: _____

MEDICAL INFORMATION

Current Medical Center for treatment: _____

Date of Diagnosis (approx): _____ Age of Onset: _____ # of Surgeries: _____

Would you volunteer for a clinical trial? Yes No

Are there other pituitary patients in family? Yes No

If so, who? _____ Children: Female _____ Male _____

MEMBERSHIP SELECTION

- ❑ **$45 Membership Renewal**
- ❑ **$55 Standard New Membership**
- ❑ **$75 Standard Plus Membership**
- ❑ **$100 Family Membership (Up to 4 family members)**
- ❑ **$125 Patron Membership**
- ❑ **$180 Complete Membership**
- ❑ **$500 Lifetime Membership w/ Resource Guide**
- ❑ **In addition to my membership, please accept my gift of $_____ as a charitable donation to the PNA**

MEMBERSHIP PAYMENT INFORMATION

- ❑ Check payable to PNA enclosed (U.S. funds only)
- ❑ Credit Card: Please charge $_____ to my credit card.
- ❑ Please circle one:

  Visa / MasterCard / Discover / AMEX

Cardholder: _____

Card #: _____

Expiration: _____

Zip Code: _____

Signature: _____

*PHYSICIAN INFORMATION (*Please provide the following so we may contact your doctor to offer a membership to him or her.)

Physician 1: General Practitioner/ OBGYN

Name: _____

Center/Affiliation: _____

Address: _____

City: _____ State: _____Zip/Postal Code: _____ Country:_____

Physician 2: Endocrinologist

Name: _____

Center/Affiliation: _____

Address: _____

City: _____ State: _____Zip/Postal Code: _____ Country:_____

Physician 3: Neurosurgeon

Name: _____

Center/Affiliation: _____

Address: _____

City: _____ State: _____Zip/Postal Code: _____ Country:_____