



PATIENT MEMBERSHIP FORM

MEMBER INFORMATION

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

Mr. Mrs. Ms. Dr. Title / Profession: _____
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

- \$55 Standard Membership**
- \$100 Patron Membership**
- \$200 Sponsor Membership**
- \$500 Lifetime Membership w/ Resource Guide**
- I would like to make a tax deductible, charitable donation.** (Please see attached donation form.)

MEMBERSHIP PAYMENT INFORMATION

- Check payable to PNA enclosed (U.S. funds only)
- Credit Card: Please circle one:

 Visa / MasterCard
- Cardholder: _____
- Card #: _____
- Expiration: _____
- Signature: _____

PHYSICIAN INFORMATION (Please provide the following information so that we may contact your doctor, in order 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: _____