

American Partnership for Eosinophilic Disorders Membership Application

Federal ID Number: 76-0700153

www.apfed.org

Please print clearly

Name: _____

Mailing Address: _____

City: State/Province: _____ Zip/Postal Code: _____

Country: _____

E-mail address: _____ Telephone number: (____) _____

By submitting your e-mail address, you agree that APFED can contact you via e-mail to provide online newsletters and information. You may unsubscribe at any time by contacting webmaster@apfed.org Your personal information will remain confidential and will not be sold or given to anyone outside of APFED without consent from you.

Benefits of Membership

- Membership fees help cover APFED operational costs.
- Newsletter and Updates, Advance Notice of Conferences.
- Medical Studies and Medical Breakthroughs.
- Emotional Support.
- Increased Public Awareness.
- Access to the APFED message board.

I would like to join or renew my APFED membership.

(Membership year is January 1st thru December 31st)

Household membership per year

United States \$30

Canadian \$45

Euro/Australian \$55

Professional affiliate membership per year

United States \$100

Canadian \$125

Euro/Australian \$150

I would like to make a donation for ___ \$50 ___ \$100 ___ \$250 Other \$ _____

Payment type:

Check/Money Order

Credit Card (Secure on-line credit card processing for membership www.apfed.org/join.htm)

(Secure on-line credit card processing for donations www.apfed.org/donations.htm)

Or for check/money order

Please submit application and remit payment to: APFED

PO Box 29545

Atlanta, GA 30359

How did you hear about APFED? Please list any/all eosinophilic patients in

___ APFED Brochure your household:

___ Friend/Family member Example, Jimmy, EE, age optional

___ Online support group _____

___ Allergist/Immunologist _____

___ Gastroenterologist _____

___ Pediatrician/Primary Physician _____

___ Website _____

___ Other, please describe: _____