



SPINA BIFIDA ASSOCIATION OF IOWA

Membership Form

**Please circle YES or NO
for the following questions:**

1. You have my permission to print the information to the right in the SBAI Membership Directory.

YES NO

2. I would like to help the association by volunteering. I can offer skills in the following areas:

Please contact me.

YES NO

Please accept my donation of \$_____ to help offset the funding of the Spina Bifida

Association of Iowa's:

- Quarterly Newsletter
- Reimbursement Program
- Chapter and Member Services

If you cannot donate at this time, please enter a zero on the line.

Signature

Date

This is the information we have for you, please make corrections below. If no label is attached, or there is missing information, please provide us with your contact information below.

Name:

Street Address:

City:

State:

Zip:

Phone:

Email:

Please check the appropriate category:

___ I am an adult with spina bifida.

My birthdate is _____.

___ I am a parent of a child with spina bifida.

Our child's name is _____.

Their birthdate is _____.

___ I am a relative of someone with spina bifida.

The name of that person is _____.

Their birthdate is _____.

___ My connection to spina bifida is:

_____.

Mail this form and your donation to:

Spina Bifida Association of Iowa

P.O. Box 1456

Des Moines, IA. 50305

Office Use: