



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 am willing to help the association connect families with similar issues.

YES NO

I have experience with:

I would like information on:

3. I would like to help the association by volunteering. 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

Office use:

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.

My 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