

# MINNESOTA SPINA BIFIDA ASSOCIATION

## 2014 Membership Form

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Telephone \_\_\_\_\_  
Email \_\_\_\_\_

Please Check One

Parent \_\_\_\_\_ Guardian \_\_\_\_\_ Grandparent \_\_\_\_\_  
Individual with Spina Bifida \_\_\_\_\_ Professional \_\_\_\_\_  
Other (please specify) \_\_\_\_\_

Child's Information (if applicable)

Name \_\_\_\_\_  
Birth Date \_\_\_\_\_

### Membership Dues

\_\_\_\_\_ Local only (\$20)  
\_\_\_\_\_ Professional (\$50)  
\_\_\_\_\_ Patron (\$100)

\_\_\_\_\_ I am unable to pay at this time  
\_\_\_\_\_ I would like to sponsor a member(s)  
\_\_\_\_\_ I would like to be contacted by another parent  
\_\_\_\_\_ I would like to be contacted by an adult with Spina Bifida  
\_\_\_\_\_ I would like to be a volunteer

Can we include your information in a local membership directory?  
Yes \_\_\_\_\_ No \_\_\_\_\_

**Together, we can make a difference!**

Mail to:  
Minnesota Spina Bifida Association  
P.O. Box 29323  
Brooklyn Center, MN 55429  
651-222-6395