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