Minnesota Spina Bifida Association
Membership Form

Name ____
Address ____
City _________________ State _____ Zip code + 4 Digit _________
Telephone # ____
Email Address____
Parent ___________ Guardian __________ Grandparent __________
Individual with Spina Bifida___________________________________
Other (Please specify) _______________________________________
Professional ____
Child Information:
Name ____
Birth Date ____

Membership Dues

____ Membership $20.00
____ Professional $50.00
____ Patron $100.00
____ I am unable to pay at this time, but wish to receive the local mailings.
____ 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.
____ Yes ____ No Can we include your information in a local Membership directory?

Together, we can make a difference!

Make Checks Payable to MNSBA
Mail back to:
Minnesota Spina Bifida Association
P.O. Box 29323
Brooklyn Center, MN 55429
651-222-6395
Website: MNSBA.org
Email: SBAMN@hotmail.com