

To join the International Waldenstrom's Macroglobulinemia Foundation, please print out this form, fill it out and fax or mail to the Foundation.

Date _____

Phone Number _____

Email address _____

Name _____

Address _____

City _____ State _____ Zip _____

Are you a Waldenstrom's Patient? _____ Caregiver _____ Family member _____ Friend _____

If you are not the patient, can you give us their name Please _____

For our statistics: Age of patient? _____ Gender _____ Month/Year of Diagnosis? _____

Your relationship to patient? _____ Is Patient under Treatment now? _____

Do you want us to contact you? _____ Where/how? _____

Have you received the IWMF InfoPak? _____ Do you want to receive it? _____

Would you like to participate in our Telephone/E-mail Network List? _____

Any other pertinent information you can provide will help us to tailor our response to you.

Contributions to the IWMF are not required for membership. However, the Foundation depends solely upon member donations to fund our member services, medical research, web site and publications program. Please contribute what your heart asks and your pocket can afford.

You can send a check or use a credit card by filling out the below, or by calling the office.

Amount \$ _____

Type of Card _____ Card No. _____ - _____ Expiration Date _____

Name on Card _____ Phone number (if different) _____

Billing Address _____ City _____ State _____ Zip _____

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IWMF

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Sarasota, FL 34231

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