

# 2003-4 Membership Application / Renewal

## Velo-Cardio-Facial Syndrome Educational Foundation, Inc

**Name:** \_\_\_\_\_  
First Middle Last

**Street / Apt:** \_\_\_\_\_

**City/St/Zip:** \_\_\_\_\_  
City State / Province Postal Code USA Country (if not)

**Contact Phone:** \_\_\_\_\_ **Ext:** \_\_\_\_\_  
Country Code (if not US) Area Code Phone Number

**Fax:** \_\_\_\_\_ **E-Mail:** \_\_\_\_\_

What is your interest in velo-cardio-facial syndrome? (Optional)

- I have velo-cardio-facial syndrome
- I am the parent of someone with velo-cardio-facial syndrome
- I am a student or resident interested in learning more about velo-cardio-facial syndrome
- Other (please explain): \_\_\_\_\_
- I am a professional/health care provider working with individuals with velo-cardio-facial syndrome.  
(complete section below)

Field \_\_\_\_\_ Degree(s): \_\_\_\_\_ Certified or licensed? yes \_\_\_ no \_\_\_

How did you find out about the Foundation? \_\_\_\_\_

Send this completed form to: **Lisa M. Jennings**  
 Velo-Cardio-Facial Syndrome Educational Foundation  
 385 North St  
 Weymouth, MA 02191  
 Telephone: 1-732-238-8803  
 Toll Free: 1-866-VCFSEF 5 (1-866-823-7335)

**MEMBERSHIP TYPE: ( CHECK ONE )**

<input type="checkbox"/> Single - \$40.00	<input type="checkbox"/> Family - \$50.00	<input type="checkbox"/> Student - \$20
<b>Voluntary:</b> \$_____ Caitlin Lynch Memorial Fund        \$_____ Tony Lipson Memorial Fund		
<input type="checkbox"/> Request waiver of annual dues for 2003-4	<input type="checkbox"/> Check Enclosed for \$_____ Chk#:_____ <input type="checkbox"/> PayPal	

- New Membership**             **Renewal Membership**             **Note change of address**

<p><b>AUTHORIZATION TO RELEASE INFORMATION</b>  <i>(check all that apply)</i></p> <p>I hereby authorize the <b>Educational Foundation</b> to release my information <b>as indicated below</b>, to <b>other members</b> and to publish it in a directory <b>for members</b>. The purpose for this permission is to connect people in localities so that support can be offered and information distributed. The Foundation WILL NOT distribute, sell, or otherwise release this information for any other purpose, or for the enhancement of individual doctors or hospitals.</p> <p>You may release my:   <input type="checkbox"/> Name   <input type="checkbox"/> Address   <input type="checkbox"/> Phone #   <input type="checkbox"/> Email address   <input type="checkbox"/> <b>Release NONE</b></p> <p><b>Signature:</b> _____ <b>Date:</b> _____</p>
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