Knowledge is Hope

VCFS Educational Foundation, Inc.

Velo-Cardio-Facial Syndrome Educational Foundation, Inc.
2008 Membership Application / Renewal

❑ **New Membership** ❑ **Renewal**

First & Last Name: _____

Include family members by providing name, relationship, age of child & VCFS diagnosis as applicable:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Mailing Address: _____

❑ **home** ❑ **work**

❑ **Change of address**

_____

City State / Province Postal Code Country (if not USA)

E-Mail: _____

Contact Phone: (_____)_____**Ext:**_____

Area or Country Code

❑ **Full Membership - $40** ❑ **2-Years - $75**

___ I have Velo-Cardio-Facial Syndrome

___ I have a family member with Velo-Cardio-Facial Syndrome

___ I am a professional working with individuals with VCFS. *Field*_____

___ Other: _____

❑ **Student - $20** Professional degree student or resident interested in a VCFS related field of study

Field _____

Dues $____

❑ Request waiver of annual dues for 2008

VCFSEF, Inc is a US 501(c)(3) non-profit organization. Donations are US tax-deductible to the fullest extent of the law.

Please consider a donation to support our efforts:

Founder's Circle	$ 1,000
Benefactor	$ 500
Caitlin Lynch Memorial Fund	$ _____
Tony Lipson Memorial Fund	$ _____
Amanda McPherson Fund	$ _____
Kid's Zone Fund	$ _____
In Honor of: _____	$ _____
In Memory of: _____	$ _____

Payment options: **Online** http://www.vcfsef.org/onlinedues.html

Check payable to VCFSEF, Inc **Total Enclosed $ _____**

Please send this completed form and payment to:

Velo-Cardio-Facial Syndrome Educational Foundation, Inc
Membership
PO Box 874
Milltown, New Jersey 08850

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the **Educational Foundation** to release my contact information **as indicated below**, to **other members** and to publish it in a directory **for members.** 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. You may release my: ❑Name ❑Address ❑Phone # ❑Email address ❑**Release NONE**

Signature: _____ *Date:* _____