



MEMBERSHIP FORM

Your membership helps the work of the ABDA in locating patients with Behçet's Disease, providing information and support to patients and their families, and educating medical professionals.

YOU CAN ALSO REGISTER ON-LINE AT: www.bhecets.com/join

MEMBERSHIP PRIVILEGES

An ABDA membership entitles you to several privileges:

- Newsletter subscription and informational mailings.
- The ability to submit stories, recipes, etc. to share with other Behçet's patients on our Website.
- Access to the "ask the doctor" bulletin board, ABDA member directory, and medical profile service.
- Discounts on ABDA products and events.
- *And much more!*

OTHER SERVICES

- Please send me free literature about Behçet's Disease (Register me as a Web Member)
- Please send my doctor free literature about Behçet's Disease (Register me as a Web Member)

Physician Name: _____

Practice Name: _____

Specialty: _____

Office Address: _____

Office City, State, Zip: _____

Office Phone: _____

Office E-mail: _____

MEMBERSHIP FEES

Yes, I want to become a member*

* *1st time Premier memberships include a FREE one-year membership to the Vasculitis Foundation (\$25 value!)*

Please renew my membership

Name under: _____

Enclosed is my membership fee:

- Web Membership: FREE Premier 1-Yr: \$35*
(Free Literature Requests) Premier 2-Yr: \$65*
- Additional Donation: \$ _____

Note: Membership fees and donations are tax deductible to the fullest extent of the law.

PAYMENT TYPE

Enclosed is my payment of: _____

Check (Check # _____) Discover

VISA MasterCard American Express

Number: _____

Exp. Date: _____ CVV# _____

Name on Card (print): _____

Signature: _____

Please fill out this form and mail with your membership fee (payable to The American Behçet's Disease Association) to:

**The American Behçet's Disease Association
PO Box 80576 • Rochester, MI • 48308**

MEMBER INFORMATION

I am renewing and my information has changed as listed below:

Name: _____

Address: _____

City/Province: _____

State / Zip / Country: _____

Phone: _____

E-Mail: _____

OPTIONAL INFORMATION:

Primary Ethnicity: _____

Marital Status: _____

Birth Date: _____

Gender: Male Female

Do you have computer Access? Yes No

Are you on Social Security Disability

By signing here you authorize your name, address and e-mail to be printed in the ABDA Member Directory: _____

Relationship: Self (Patient) Parent Family member Friend Physician Healthcare Professional Other

Name of person with Behçet's: _____ How did you hear about us? _____