



# 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](http://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? \_\_\_\_\_