

QLA MEMBERSHIP APPLICATION

Quality Life Association, Inc.

124 North Gray Street • Millen, Georgia 30442

Phone: (478) 982-2340 • Fax: (478) 982-8219

E-mail: membership@qla-ostomy.org • Web site: http://www.qla-ostomy.org

Have you previously paid dues to QLA? Yes (Renewal) No (New member)

Member Information

Last Name First Name Middle Suffix

Street Address City State/Province Zip Code

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Telephone #1 Telephone #2 Birthday (MM/DD/YYYY)

E-mail address (print neatly)

Surgery Type (if applicable) Surgery Center Surgery Date

Membership Options

The membership period in QLA is for the calendar year, January 1 through December 31.

Single Membership, 1-year..... \$ 20.00
 *Family Membership, 1-year..... \$ 30.00
 Additional contribution or gift (tax-deductible) \$

*Family membership names: _____

Payment Options

Check (Payable to Quality Life Association, Inc)
 Credit card: Visa MasterCard American Express Discover

NAME OF CARDHOLDER

CREDIT CARD NUMBER SECURITY CODE (3 or 4 digit number) EXPIRATION DATE

SIGNATURE (must match cardholder's name)

Preferences (Optional)

Preferred method of communication with QLA? E-mail US Mail
Preferred delivery method of the *Horizons* newsletter? E-mail Web site US Mail

Please read, check, and sign to complete application

I hereby apply for membership in the Quality Life Association and understand I am eligible to continue my membership as long as I remain within the guidelines of the QLA Bylaws. I am submitting the appropriate and required membership dues along with this application to the address shown below.

Signature _____ Date _____

Please return application and dues to:

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