QLA MEMBERSHIP APPLICATION

Quality Life Association, Inc.
4327 S. Hwy 27, #417 • Clermont, Florida 34711
Phone: (352) 394-4912
E-mail: membership@qla-ostomy.org • Web site: http://www.qla-ostomy.org

Have you previously been a member of QLA? ___ Yes (Renewal) ___ No (New member)

Member Information*

_____
Last Name First Name Middle Suffix

_____
Street Address City State/Province Zip Code

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

_____
E-mail address (print neatly)

_____
Surgery Type (if applicable) Surgery Center Surgery Date

*All personal information is held in the strictest of confidence. No membership data will be sold or distributed to third-party vendors without your approval.

Membership Options

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

___ Single Membership, 1-year (tax-deductible).....$ 20.00
___ **Family Membership, 1-year (tax-deductible) .....$ 30.00
___ Additional contribution or gift to QLA Operating Account (tax-deductible) .....$_____
___ Additional contribution or gift to QLA Fund (tax-deductible).....$_____
**Family membership names:_____

Payment Options

___ Check (*Payable to Quality Life Association, Inc*)
___ Credit card: [ ] Visa [ ] MasterCard

_____
NAME OF CARDHOLDER

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

_____
SIGNATURE (must match cardholder's name)

Please read, check, and sign to complete application
___Please remove my name from your mailing list.

___ 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:
Quality Life Association, Inc • 4327 S. Hwy 27, #417 • Clermont, FL 34711