

# C.O.A. MEMBERSHIP APPLICATION

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE: (    ) \_\_\_\_\_

PLEASE CIRCLE: COLOSTOMY ILEOSTOMY UROSTOMY CONTINENT UROSTOMY

CONTINENT ILEOSTOMY J- POUCH OTHER \_\_\_\_\_

DATE OF SURGERY: \_\_\_\_\_ MALE (    ) FEMALE(    )

I DO NOT HAVE AN OSTOMY. I AM: SPOUSE PARENT PROFESSIONAL

OTHER \_\_\_\_\_

DUES \$10.00 \_\_\_\_\_ CONTRIBUTION \_\_\_\_\_

*\*If unable to pay, please contact the president of C.O.A. This must be done*

*annually as your situation may change.*

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Please complete this form and mail with your payment to:

C.O.A.

P.O. BOX 43114

RICHMOND HTS., OHIO 44143

Please make all checks payable to: Cleveland Ostomy Association