SPINA BIFIDA ASSOCIATION
OF CONNECTICUT

P.O.BOX 2545
HARTFORD, CT 06146-2545

SBAC Annual Information Update

Name _____

Spouse's Name _____

Address _____Apt # _____

City _____ State _____ Zip +4 _____

Home phone ( ) _____Work phone ( ) _____

E-mail address _____ Fax number ( )_____

[ ] add me to your e-mail list for alerts and breaking news.

[ ] use it only as contact method

Please check the one that best describes your status:

_____ Adult with spina bifida

_____ Parent/Guardian of a child with spina bifida. Name of child with spina bifida

Name _____Date of birth _____

_____ Family member, grandparent or other extended family. (Please specify) _____

_____ Medical or Educational Professional Member (Please specify profession)_____

_____ Other (friend, student, etc.) _____

Donation (Optional)

I would like to support the efforts of the SBAC with the following donation:

( ) $25 ( ) $50 ( ) $75 ( ) $100 ( ) Other _____