

Acoustic Neuroma Association of Canada (ANAC) Application Form

You may be part of ANAC in the following ways:

1. Patient Registry only (free)
 - ✓ your name and medical history is captured on a database of other Canadian AN patients (**ANAC will not share this information with any other organization**)
 - + you receive a tax receipt for any/all donations of \$10 or more
 - I wish to be part of the patient registry only

2. Regular Member
 - 1 year (January to December, 2009) = \$40.00 (a \$35.00 tax receipt will be issued)**

 - 3 year membership (January, 2009 to December, 2011) = \$105.00 (a receipt of \$100.00, with 2 years of “free newsletters”)**
 - ✓ your name and medical history is captured on a Canadian database of other AN patients (**ANAC will not share this information with any other organization**)
 - + you receive a tax receipt for your membership fee and any/all donations of \$10 or more
 - + you receive the ANAC newsletter ‘the Connection’ which is published three times / year
 - + you are invited to share your story as a peer support volunteer
 - + you have voting privileges as to the decisions made by the Association and to vote for members of the board of directors
 - + you are eligible to serve as a Board Director and/or Chapter Leader

PLEASE COMPLETE THIS FORM AND RETURN TO:

Acoustic Neuroma Association of Canada

171A Rink Street, Suite 163

Peterborough, ON K9J 2J6

Phone: 1-800-561-2622 / (705) 750-1550

Email: info@anac.ca Website: www.anac.ca

Name: _____

Address: _____

City/Prov/Postal code: _____

Residence Phone: _____

Fax and/or Email: _____

Please complete your medical history on the next page so we can ensure we have up-to-date information.

I am:

present / former patient family member friend
 medical professional (specify) _____
 Other (please specify) _____

Language of Choice: _____

Year of Birth: _____

Medical Condition: (check all that apply)

Acoustic Neuroma Bell's Palsy Meningioma NF2
 Other (please specify) _____

At the time of your diagnosis what size was your acoustic neuroma? _____ **cm**

I have been affected in the following ways: (check all that apply)

Mouth (dental, TMJ, etc.) Nose
 Ears (hearing loss, tinnitus, etc.) Throat
 Head (headaches, dizziness, balance, etc.) Facial Muscles
 Psychological (depression, anxiety, etc.) Fatigue
 Eyes (dryness, sensitivity to light, blurred vision, tear production, lid closure, etc.)
 Other (please specify) _____

Medical Treatment #1: Treatment location (city) _____ **; Year** _____ **;**

Dr. _____
 Monitoring / Number of years _____
 Gamma Knife
 LINAC
 Surgery
 Other (please specify) _____

Medical Treatment #2: Treatment location (city) _____ **; Year** _____ **;**

Dr. _____
 Monitoring / Number of years _____
 Gamma Knife
 LINAC
 Surgery
 Other (please specify) _____

Members only:

I am willing to receive the newsletter electronically (as a cost saving measure)

_____ Yes, Email address _____ No

I am willing to share my name and personal experience with other patients

_____ Yes, Please sign here _____ No

Payment Options:

___ cheque or money order (Payable to “Acoustic Neuroma Association of Canada” or “ANAC”)

___ Mastercard or VISA # _____

Amount _____ Expiry Date _____

Name on the card _____

Signature _____

Donations: Tax receipts are issued for all donations over \$10

Your donation will help us to continue assisting newly diagnosed patients and their families as well as keeping each other informed.

___ General

___ In honour of (name) _____

(address) _____

___ In memory of (name) _____

(address) _____

**A PLANNED GIFT
Today
is a wonderful way to pass on your legacy
Tomorrow.**

Be part of building our organization for the future. Your planned gift to ANAC – no matter what size – has the potential to change the life of someone tomorrow.

For information on planned giving, please contact **Melanie Sexsmith** at info@anac.ca