

Acoustic Neuroma Association of Canada (ANAC) Application / Donation Form

You may be part of ANAC in the following ways:

1. Regular Member

1 year = \$40.00 (a \$35.00 tax receipt will be issued)

- ✓ 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

2. Patient Registry only (free)

I wish to be part of the patient registry only

- ✓ 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

PLEASE COMPLETE THIS FORM AND RETURN TO:

Acoustic Neuroma Association of Canada

162 Bonnie Doon Shopping Centre

PO Box 68028

Edmonton, AB T6C 4N6

Phone: 1-800-561-2622 Fax: (780) 465-0339

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)

<input type="checkbox"/> Mouth (dental, TMJ, etc.)	<input type="checkbox"/> Nose
<input type="checkbox"/> Ears (hearing loss, tinnitus, etc.)	<input type="checkbox"/> Throat
<input type="checkbox"/> Head (headaches, dizziness, balance, etc.)	<input type="checkbox"/> Facial Muscles
<input type="checkbox"/> Psychological (depression, anxiety, etc.)	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Eyes (dryness, sensitivity to light, blurred vision, tear production, lid closure, etc.)	
<input type="checkbox"/> 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 (only names of Regular Members are shared)

_____ 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 Cheryl Bauer at info@anac.ca