HEMOPHILIA ASSOCIATION OF NEW JERSEY

Member Registration Form

The information you provide is strictly confidential and is only to provide more effective services to you. The information will not be released to any other group or individual without your written consent.

Name _____ Date _____

(Person with bleeding disorder)

Date of birth _____

Gender
- ◯ Male
- ◯ Female
- ◯ Non-Binary
- ◯ Choose not to answer
- ◯ Other

Address _____

(Street Address)

_____

(City)

_____

(County)

_____

(State)

_____

(Zip Code)

Name of person mail should be addressed to:

_____

(First)

_____

(Last)

Phone #

_____

(Cell)

_____

(Work)

_____

(Home)

Email Address _____

Type of bleeding disorder _____

Are there inhibitors?
- ◯ Yes
- ◯ No

What level or severity are you?
- ◯ Mild
- ◯ Moderate
- ◯ Severe

Name of company that delivers your factor _____

Do you use nursing services for your factor? ◯ Yes ◯ No

Name and address of hospital (HTC) at which you are usually treated

_____

(Name)

_____

(Address)

Name of doctor at Hemophilia Treatment Center

Name of social worker at Hemophilia Treatment Center

If minor:

(Father's Name)

(Mother's Name)

(Guardian's Name if not parent)

(Relationship)

Please specify ethnicity

- ◯ Hispanic or Latino
- ◯ Non Hispanic or Latino

Please specify race

- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black or African American
- ◯ Native Hawaiian or other Pacific Islander
- ◯ White
- ◯ I decline to answer

Is the person being registered

- ◯ Student
- ◯ Employed
  - ◯ Full-time
  - ◯ Part-time
- ◯ Unemployed
- ◯ Retired
- ◯ Other

Name and address of school or employer

Occupation

Are you interested in serving on an HANJ volunteer committee? ◯ Yes ◯ No

What program(s) would you like to see HANJ offer?

Please submit this registration via mail, fax or email to :

Hemophilia Association of New Jersey
197 Route 18 South, Suite 206 North
East Brunswick, NJ 08816
Fax: 732-249-7999 Email: info@hanj.org