4976 Eichelberger Street, St. Louis, MO 63109
(314) 482-5973
Email: info@gatewayhemophilia.org

GHA MEMBERSHIP FORM

Member(s) Name(s): _____

Address**:** _____

City: _____ State: _____ Zip:_____

Phone: Home: (____**)** _____Cell: (_____**)** _____

Email address: _____ Employer _____

Bleeding Disorder _____ Name of HTC _____

☐ Would you like to receive the newsletter via email?

Please complete the following information for EVERY family member that is considered part of this membership. (Bleeding Disorder Yes = someone who has a confirmed diagnosis and has a treatment plan.)

Family Member 1 Name: _____ Date of Birth: _____
This family member has a Bleeding Disorder: Yes or No Is yes, Bleeding disorder_____

Family Member 2 Name: _____ Date of Birth: _____
This family member has a Bleeding Disorder: Yes or No Is yes, Bleeding disorder_____

Family Member 3 Name: _____ Date of Birth: _____
This family member has a Bleeding Disorder: Yes or No Is yes, Bleeding disorder_____

Family Member 4 Name: _____ Date of Birth: _____
This family member has a Bleeding Disorder: Yes or No Is yes, Bleeding disorder_____

Family Member 5 Name: _____ Date of Birth: _____
This family member has a Bleeding Disorder: Yes or No Is yes, Bleeding disorder_____

Family Member 6 Name: _____ Date of Birth: _____
This family member has a Bleeding Disorder: Yes or No Is yes, Bleeding disorder_____

Signature: _____Date: _____