GATEWAY HEMOPHILIA ASSOCIATION

4976 Eichelberger Street
St. Louis, MO 63109

Phone: (314) 482-5973 **Email:** info@gatewayhemophilia.org

GHA MEMBERSHIP FORM

Member Name: _____ **Date of Birth**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone: (_____)_____ **Email address**: _____

Bleeding Disorder Type: ☐ Hemophilia A ☐ Hemophilia B ☐ vWD ☐ Platelet Disorder ☐ Factor VII
☐ Factor X ☐ Factor XI ☐ Factor XII ☐ Other (please describe) _____

Type of Community Member: ☐ Person with a bleeding disorder ☐ Parent of a person with a bleeding disorder
☐ Spouse of a person with a bleeding disorder ☐ Grandparent of a person with a bleeding disorder
☐ Other (please describe) _____

Name of Hematologist/HTC _____ **Employer** _____

What kind of insurance do you have? ☐ Medicaid ☐ Medicare ☐ Marketplace ☐ Tricare ☐ Employer Plan
☐ Individual Insurance Plan ☐ Unknown

What is your preferred way to receive communication from us? ☐ Text ☐ Email ☐ Phone call

☐ Would you like to receive GHA's Newsletter via email?

Please complete the following information for EVERY family member that is considered part of this membership.

Additional Household Member: _____ Date of Birth: _____
Type of Community Member: _____ Bleeding Disorder Type: _____

Additional Household Member: _____ Date of Birth: _____
Type of Community Member: _____ Bleeding Disorder Type: _____

Additional Household Member: _____ Date of Birth: _____
Type of Community Member: _____ Bleeding Disorder Type: _____

Additional Household Member: _____ Date of Birth: _____
Type of Community Member: _____ Bleeding Disorder Type: _____

Additional Household Member: _____ Date of Birth: _____
Type of Community Member: _____ Bleeding Disorder Type: _____

Signature: _____ Date: _____