



<u>Office Use Only</u>	
NMM: _____	From: _____
Member Number: _____	To: _____

Gilda's Club Grand Rapids Membership Information

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____ County: _____

Male/Female: _____ Please email me the calendar monthly _____

Check one (optional): African American ____, Asian American ____, Hispanic ____,
Native American ____, White/Caucasian ____

Employer (if any): _____

Occupation: _____ How did you hear about Gilda's Club? _____

Do you wish to receive information about donating to Gilda's Club, fundraising events and activities? Yes ___ No ___

Cancer Connection

I was diagnosed: _____ My loved one was diagnosed: _____ Type: _____

Name and relationship: _____ Date Diagnosed: _____

Your Medical Information

Primary physician: _____ Oncologist: _____

Hospital _____

Contact Information

Emergency contact name, relationship and phone number: _____
