

MEMBERSHIP REGISTRATION FORM

Member name:

REGISTRATION TYPE:	JOINED BY:
A person with limb loss	Louisville meetingLouisville event
A caregiver	Indiana meetingIndiana event
Other (friend, relative, business professional)	FacebookOther
ABOUT YOU:	CONTACT PREFERENCE:
Under age of 18 Over age of 18	EmailPhone
DOB:/	
Veteran: Y N	MailFacebook
CONTACT INFO:	
Address:	
(House #) (Street name)	(City) (State) (Zip)
Email:@	Phone:
ADDITIONAL INFO ABOUT YOU (Optional):	
NEWSLETTER:	MEMBER CONTACT LIST:
Receive via EmailReceive via Facebook	Ok to share with group members
Receive via MailDo NOT wish to receive	Only share with officers to contact me
GROUP MISSION: To reach out and empower people affected by limb loss to achieve their full potential through education, support, and advocacy; and to raise awareness of limb loss by becoming actively involved in our community.	
I,, am registering to become a member of MOVING FORWARD. In doing so, I agree to support the mission statement of the organization and to abide by its bylaws.	
Signed,	
	Date: