Queens Sickle Cell Advocacy Network

Membership Application

Information and Refferral Center
Servicing Children and Families
with Special Needs

205-14 Linden Blvd. Suite 206
St. Albans, N.Y. 11412
Tel: (718)712-0873
Fax: (718)712-0198

Please Print or Type

Name_____
Last First Middle Initial Birth Date Gender

Mailing Address: _____

Home Tel: _____ Work Tel: _____ Best time to call _____

Place of employment: _____

_____

Occupation: _____

1. Who referred you/ how did you hear about QSCAN? _____
2. Why would you want to become a QSCAN member? _____
3. What skills are you able to contribute to QSCAN? _____
4. What is your special interest in Sickle Cell disease _____
5. What comitee would you like to participate on? _____
6. What other organization and / or association are you affiliated with? _____
7. Are there any other QSCAN members in your household? Yes No If yes, please list below.
   1. _____
   2. _____

Membership Dues

Annual dues are $20.00 per person and shall apply from March - through February of the following year.

Dues $ _____
Additional donation for the organization programs and optional expenses $ _____
Total amount enclosed $ _____

I will comply, accept and respect the policy of the organization and to refrain from using the name or logo of QSCAN, with out the approval of the board of directors of QSCAN. I also agree to comply with QSACN Constitution by-laws and policies.

Signature: _____ Date: _____

***New Members are welcome. Increase yoyr awareness of sickle cell disease by getting involved.
With us working together we can make a difference!