OUR MISSION STATEMENT:

With the guidance of a Professional Advisory Board, our volunteer Board of Directors establishes programs to train visitors of all ages, including teens, young adults, caregivers and parents of children with ostomies. We publish a newsletter and conducts meetings all to support those needing advocacy in coping with the adjustments associated with diversion and continent surgeries.

OSTOMY SUPPORT GROUP OF NORTHERN VIRGINIA, LLC

Support Group Phone Number:

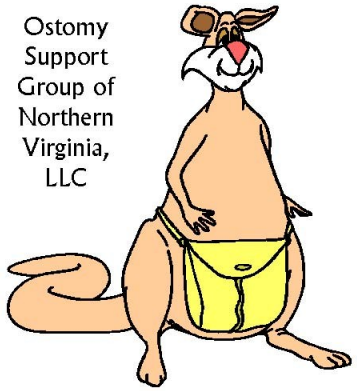
703-802-3457

Treasurer/Membership :

Mailing address: PO Box 231642, Centreville, VA 20120

E-Mail: Datreasosgnv@verizon.net

All information contained in this application will be kept in the strictest of confidence and will not be provided to others outside of the OSGNV, LLC.



MEMBERSHIP APPLICATION

Membership special:
Anyone joining OSGNV, LLC will receive a complimentary one-year subscription, a $29.95 value, to "The Phoenix", the official publication of the UOAA.

*Ostomy Support Group of Northern Virginia, LLC (OSGNV, LLC) is an Affiliated Support Group of United Ostomy Associations of America, Inc.

MEMBERSHIP APPLICATION

OSTOMY SUPPORT GROUP OF NORTHERN VIRGINIA, LLC

Please enroll me in the Ostomy Support Group of Northern Virginia, LLC. Dues are *$20.00* per year* and include support group meetings, and "The Pouch" newsletter.

Dues are fully deductible under IRS regulations. Tax ID Number: 54-1147876.

Member Information: **Date:**_____

Name: _____ **Gender:** _____

Address: _____

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

Date of Birth: _____**Phone Number:** _____

E-Mail Address: _____

Procedure/Relationship (check all that apply)

Colostomy: _____ **Ileostomy:** _____ **Urostomy:** _____ **J-Pouch/Pull Through:** _____

Continent Urostomy: _____ **Other Continent Procedure:** _____

Other: _____

Date of Surgery: _____

Reason for Surgery:

Colon/Rectal Cancer: ___ **Bladder Cancer:** ____ **Other Cancer:** ___ **Ulcerative Colitis:** ___

Crohn's Disease: ___ **Congenital Condition:** ___ **Other:** _____

How did you hear of us? (Please give name).

Pharmacy: _____ **Ostomy Nurse:** _____

Hospital: _____ **Doctor:** _____

Web Site (which one?) _____ **Other:** _____

Please make your check for $20.00 payable to: Ostomy Support Group of Northern Virginia, LLC or OSGNV, LLC and mail to: OSGNV, LLC, c/o William W. Hawes, Treasurer, PO Box 232107, Centreville, VA 20120-8107

(Dues at the regular level may be waived by the Board of Directors for any applicant who expresses , in writing, an inability to pay. Such a waiver must be revised/renewed annually.)