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.

**OUR MISSION STATEMENT:**

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.*
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.

MEMBERSHIP APPLICATION

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: 54-1477876.

Date: _________________________ Name: __________________________________________

Gender: _______ Address: _____________________________________________________________

City: ____________________________ State: _______ Zip: _______________

Date of Birth: _____________________ Phone Number: _____________________

Procedure/Relationship (check all that apply)

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

Continent Urostomy:  _____  Other:  ________________________________________________

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:  ________________________________

(Check one) Pouch: ____________  Anal Pouch: ______  Donut/Comb: ____________

Date of Birth: _________________________ Phone Number: _____________________

CHY: ____________________________  Zip: _______________ State: ____________

Address: _____________________________________________________________

Gender: __________________________________________

Name: __________________________________________

Date: __________________________________________

* 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 renewed/extended annually.

OSTOMY SUPPORT GROUP OF NORTHERN VIRGINIA, LLC

MEMBERSHIP APPLICATION