AFI Member Form

Date Received: _____

I am a (check all that apply):

____ Parent of a child with aniridia who is 17 years or younger
____ Parent of a child with aniridia who is now an adult (fill in relative w/ aniridia below)
____ I have aniridia. My birthdate is: (M/D/Y) _____
____ My relative has aniridia. He/she is my _____ Male or Female _____
Name: _____ Birthdate: (M/D/Y) _____

(Employment information helps AFI find opportunities to utilize member skills and company donation matching programs. AFI will never contact companies. Sporadic Aniridia means neither parent has aniridia; Familial Aniridia means that a parent has aniridia. Race is asked for statistical research data. If genetic testing has been done, please attach all genetic reports for the AFI Medical Registry.)

Annual Member Fee and Level Selection

I will pay my annual member fee of $120 by ___check or ___credit card as described below.

Please refer to your membership brochure and select a member level:
___ Stargazer Circle with $ _____ monthly donations (not required but encouraged)
___ Angel Circle with $ _____ monthly donations (refer to brochure for range)
___ Guardian Angel Circle with $ _____ monthly donations (refer to brochure for range)
___ Archangel Circle with $ _____ monthly donations (refer to brochure for range)

Monthly Donations:

To set up your monthly sustenance donation for your circle level, go to http://weblink.donorperfect.com/AFI_MONTHLY

Member submissions:

Online submissions: Fill in the pdf form and send via email to register_afi@make-a-miracle.org. To pay your annual member fee of $120, submit your payment via credit card to http://weblink.donorperfect.com/fee.

(Please note: If you are a Mac user, please do not fill in the form using Mac Preview. Download the pdf file and use Acrobat Reader instead.)

Submission by postal mail: Fill in, print form and mail along with your check payable to "Aniridia Foundation International" to our address:

Aniridia Foundation International
P.O. Box 800715 (Ophthalmology)
Charlottesville, VA 22908-0715

Head of Household

First Name: _____ Last Name: _____ Male or Female: ____

Area of Employment: _____ Company: _____

If diagnosed with aniridia, please fill out the following: Birthdate (M/D/Y): _____

Sporadic or Familial: _____ Race: _____

Spouse

First Name: _____ Last Name: _____ Male or Female: ____

Area of Employment: _____ Company: _____

If diagnosed with aniridia, please fill out the following: Birthdate (M/D/Y): _____

Sporadic or Familial: _____ Race: _____

Address

Street: _____

City: _____ State: _____ Zip: _____

If outside of USA, list province and country: _____

Home Phone: _____

Cell Phone: _____ **Spouse Cell Phone:** _____

Preferred Email: _____

Secondary Email: _____

(Please put aniridia@make-a-miracle.org in your address books to avoid important information mailings and invitations going into your SPAM folder.)

Children under 18 years with aniridia

Child 1: First Name: _____ Last Name: _____ Male or Female: ___

Birthdate (M/D/Y): _____ Sporadic, Familial _____ Has WAGR? _____

Race _____ Has had genetic testing? (yes or no) ____ Contact me ___

Child 2: First Name: _____ Last Name: _____ Male or Female: ___

Birthdate (M/D/Y): _____ Sporadic, Familial _____ Has WAGR? _____

Race _____ Has had genetic testing? (yes or no) ____ Contact me ____

Child 3: First Name: _____ Last Name: _____ Male or Female: ___

Birthdate (M/D/Y): _____ Sporadic, Familial _____ Has WAGR? _____

Race _____ Has had genetic testing? (yes or no) ____ Contact me ____

(continued)

Child 4: First Name: _____ Last Name: _____ Male or Female: ___
Birthdate (M/D/Y): _____ Sporadic, Familial _____ Has WAGR? _____
Race _____ Has had genetic testing? (yes or no) ____ Contact me ___

(If you have more than four children with aniridia, please attach a sheet of paper or additional word document.)

Children without aniridia

(Registered children will be allowed to attend conferences, social gatherings, children's programs with their siblings and help with family statistical information.)

Name: _____ Birth Year: _____
Name: _____ Birth Year: _____
Name: _____ Birth Year: _____
Name: _____ Birth Year: _____

To help AFI evaluate communications and activities, our household uses:

___ Zoomtext Software Used by: _____ (name(s))
___ Screen Reader (Audio) Software Used by: _____ (name(s))
___ Guide Dog Used by: _____ (name(s))

Tax deduction receipt choice:

We are a 501(c)3 non-profit organization and all donations are tax deductible.
I would like our tax deduction receipt letter to be sent: via email ___ via postal mail ___
(All those who donate monthly will receive a year-end receipt.)

Website: www.make-a-miracle.org **Phone:** (434) 243-3357

Aniridia Foundation International (AFI) will use postal mailings, emails and notices on our private members' website to share important, timely information. Please keep your contact information up to date by contacting the AFI office. AFI does not give out members' personal information. We recommend you do not list your contact information in your profile on our private members' website and we cannot take responsibility for your information in your profile being shared with others.

While we offer an international registration to share information and support, all AFI funding and activities will take place in the USA. We welcome and invite our active international members to attend our "Make a Miracle" conferences and other events.

Volunteers are needed the more we grow so that we can continue to put our funding into programs, research and supporting those with aniridia instead of hiring paid staff. We have come so far in 15 years. Help us keep up the momentum towards better treatments, and a cure. Please contact the AFI office if you would like a volunteer application, and AFI will help find you a volunteer position. And remember, if you do not have the time to volunteer, you can still help by becoming a monthly donor.