Membership Form

Return this form with payment to: NF Inc. Minnesota, PO Box 18246, Minneapolis, MN 55418

______ *Yes! I want to join NF Inc. Minnesota* ______ *I am a member, and I want to renew!*

Name: ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: __________

EMAIL ADDRESS: ______________________________

Membership .... $ ________

Individual (one vote) $25

Family (two votes)......................... $35

Professional (non-voting) $50

Additional Contribution .... $ ________

Total .... $ ________

Name of second adult if family membership: ______________________________

_____ I have a family member or friend with NF. Your relationship to this person? ____________

Name: ______________________ Their birth date: ______________

So that we may educate and inform your doctors about NF, please include the name(s) of the DOCTOR(S) that you or your family member sees.

In honor of: ______________________ In Memory of: ______________________

NF Inc. Minnesota is a 501(c)(3) tax exempt organization. We do not sell, rent or trade our mailing list.