THE CLEVELAND OSTOMY ASSOCIATION

MEMBERSHIP APPLICATION

NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE ( )_____

PLEASE CIRCLE: COLOSTOMY ILEOSTOMY UROSTOMY

OTHER_____

I do not have an ostomy. I am: SPOUSE PARENT

PROFESSIONAL OTHER_____

DATE OF SURGERY_____

DUES: $12.00 Annually: **Please send $1.00 for each remaining Full month left in this calendar year.**

Send check or money order to:

C.O.A.
P.O. Box 347254
Parma, Ohio 44134

DUES $_____ CONTRIBUTION $_____

If unable to pay, please contact the President. This must be done annually as your situation may change.

Contact# 440-347-0973. Don't hesitate to call with questions.