

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# 440-743-0632. Don't hesitate to call with questions.