

MEMBERSHIP ORDER FORM

Membership (circle one)

Associate Institutional (non-voting) \$40/year \$ _____
(Any hospital or professional group committed to the concept of donor human milk as part of medical treatment.)

Individual (non-voting) \$30/year \$ _____
(Interested individuals in the health professions, research, or the community.)

Donations

Your tax-deductible contributions to our operating expenses are gratefully received. \$ _____

Name: _____

Organization: _____

Address: _____

Email: _____

Phone: (work) _____ (fax) _____

Credit Card Number: _____

Expiration Date: _____

Purchase Order Number: _____

*Please make checks payable in \$U.S. to HMBANA and mail with this completed form to:

HMBANA
4455 Camp Bowie Blvd.
Suite 114-88
Fort Worth, Texas 76107, USA

Our tax identification number is 23-2533784. For questions, contact info@hmbana.org
Or call 817.810.9984

Orders can be purchase by credit card on the HMBANA Website or by calling 817.810.9984 or fax to 817.810.0087