

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](mailto: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