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: ____________________________________________________
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Address: ___________________________________________________
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Email:   ____________________________________________________
Credit Card Number:__________________________________________
Expiration Date:______________________________________________
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*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

THANK YOU!