African American Breast Cancer Alliance
AABCA
SHARE - SUPPORT - SURVIVE

PO Box 8981 - Minneapolis, MN 55408
Phone: (612)462-6813
Email: aabca@aabcainc.org
Web: www.aabcainc.org

MEMBERSHIP FORM

Our Mission

To educate and support breast and other cancer patients, survivors, their families and our community in the survival of cancer, to enhance wellness by promoting health and hope for all aspects of our lives.

Name: _____ Birth date: _____

Address: _____

City: _____ ST **MN** Zip Code _____

Phone #s: **Home** (_____) _____ **Cell** (_____) _____

E-mail _____ Fax ( ) _____

Cancer type: _____ Date(s) of diagnosis _____ _____

Treatments: ☐Surgery type _____

☐Chemotherapy ☐ Radiation ☐ Hormone ☐ Other _____

Optional: Doctors' names, Medical Center: _____

_____

I would like to participate in or receive notice of the following AABCA activities, events, or programs:

- ☐ SIS! Patient/Survivor Support Group
- ☐ Celebrations/Special Events/Retreat
- ☐ Grants, Fundraisers
- ☐ Patient Ambassador, One-on-One
- ☐ Community Education/Health Fairs
- ☐ Media/Publicity
- ☐ Development/Membership
- ☐ Conferences
- ☐ Board of Directors, Survivors Council
- ☐ Other _____

Thank you!