African American
Breast Cancer Alliance
AABCA
SHARE - SUPPORT - SURVIVE

PO Box 8981 - Minneapolis, MN 55408
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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: ____

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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!