**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.

AABCA provides monthly support group meetings for cancer fighters and survivors, Embracing Life!

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST \_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_

**Phone** #s: **Home** (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell** (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **[ ]**  Connect on Facebook

**T-Shirt Size: [ ]  Small [ ]  Medium [ ]  Large [ ]  XLarge [ ]  2XLg [ ]  3XLg [ ]  4XLarge**

**Cancer** **type**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date(s) of diagnosis \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

**Treatments**: **[ ]**  Surgery type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **[ ]**  Chemotherapy **[ ]**  Radiation **[ ]**  Hormone **[ ]**  Immunotherapy **[ ]**  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Optional***: Doctors' names, Medical Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **I am interested in the following AABCA activities, events, or programs:** | **I would like to donate on behalf of myself or someone diagnosed with cancer:** |
| * SIS! Patient/Survivor Support Group
 | NameAmount **$** \_\_\_\_\_\_\_ |
| * Celebrations/Special Events
 |
| * Board, Committee, Development
 | NameAmount **$** \_\_\_\_\_\_\_ |
| * Community Education/Health Fairs
 |
| * IT, Marketing, Media, Promotions
 | NameAmount **$** \_\_\_\_\_\_\_ |
| * Membership, Patient Ambassador, 1 to 1
 |
| * Sistas Rock Retreat
 | NameAmount **$** \_\_\_\_\_\_\_ |
| * Fundraisers, Grants
 |
| * Volunteer
 | Donations payable to: **African American Breast Cancer Alliance, Inc. (AABCA)** |
| * Other:
 |

**Please complete and return your form via Email to** **aabca@aabcainc.org****,**

**by Text to (612) 462-6813, or mail to AABCA, Inc, PO Box 8981, Minneapolis, MN 55408**

# Welcome! Thank you for your interest and support!

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***For office use only:***Cash, Check or Money order # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dated \_\_\_\_\_\_\_\_\_\_\_\_

***Total Amount $*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deposited by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_*

 AABCA Treasurer or Officer Date