

To become a member of NADF, please send your check for \$25.00 To:

**National Adrenal Diseases Foundation
505 Northern Boulevard
Great Neck, NY 11021**

_____ Become a Member \$25.00	Condition of Interest
_____ Renew Membership \$25.00	_____ Addison's Disease
	_____ Congenital Adrenal Hyperplasia
	_____ Cushing's Syndrome
	Other _____

To donate to NADF in someone's honor or memory, please indicate:

In honor of: _____

In memory of: _____

Please mark this space ___ if disease information and bulk e-mails are not desired, and you wish NADF to consider this gift as purely a donation. Thank you for your generosity!

Donation amount \$ _____ \$25 \$40 \$50 \$100 \$250 \$500

Name _____

Address _____

Phone # _____

Email Address _____

I am very happy with my doctor and would recommend him/her:

Physician Name: _____

Physician Specialty: _____

Physician Location: _____

Do you give NADF permission to share your contact information (e-mail & phone number) with other people with adrenal disease who might want to share?

Circle one: Yes or No