

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

**National Adrenal Diseases Foundation  
P.O. Box 566  
Lake Zurich, IL 60047**

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

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