CCFA Long Island
Patient & Family Services Program

Please complete the information below and return this form with the appropriate fee payable to:

CCFA, Long Island Chapter
585 Stewart Avenue, Suite 414
Garden City, NY 11530

If you are not a current paid member of CCFA, please enclose a check for $30/$60 to cover membership dues, along with **$15 per person** to cover the meeting fee. If you are a current paid member of CCFA, simply include the **$15 per person** fee to cover the meetings.

☐ Family Annual Membership ($60 if applicable)

☐ Individual Annual Membership ($30 if applicable)

☐ I am already a member of CCFA

Name: ____________________

Address: ____________________

Home Phone*: ____________________

Alt. Phone*: ____________________

Email: ____________________

*May we leave a message? ☐ Yes ☐ No

Have you participated in a CCFA Support Group? ☐ Yes ☐ No

Are you the patient? ☐ Yes ☐ No

If not, what is your relationship to the patient?____________________

Support Group I am interested in:

☐ IBD 101 ☐ Women's ☐ Men's ☐ Couples ☐ Parent's

I will attend support group with:

☐ Self ☐ Spouse - Name: ____________ ☐ Other - Name: ____________

Enclosed is my payment of $__________ ☐ Check

-OR-

Mastercard Visa American Express Discover

Credit Card #: ____________________

Exp. Date: ____________________