Dear Friend of the Bleeding Disorder Community:

It's that time of year to ask you to help support the Central California Hemophilia Foundation by becoming a member or renewing your membership. It is through the financial support of our members that we are able to provide assistance to persons with bleeding disorders and their families.

CCHF is a non-profit, ALL volunteer organization that uses all of its resources to provide services to the bleeding disorder community. Below are some of the services we provide or support:

- Scholarships: for persons with bleeding disorders
- Scholarships: for the children of persons with bleeding disorders
- Lifelong Learning Scholarship Program
- Tutoring: for youth in our community
- Educational Symposium in October 2010
- Youth and Family activities: Golf, Sunsplash, Holiday party
- Summer Camp June, in cooperation with the Hemophilia Foundation of Northern California
- Research: Judith Graham Poole Fellowship Fund
- Emergency Assistance: for persons with bleeding disorders and their families
- Legislative Advocacy: Leadership Day 5/17 -5/19, Legislative Day 5/19
- NHF Annual Meeting in New Orleans
- Medic Alert
- Research: Time For A Cure
- Newsletter: Factor Fax

Our Foundation is always looking for people interested in helping with our activities. If you would like to see our Board of Directors at work, we meet on the first Tuesday of every month at 6:00 p.m. at the Kiwanis Family House 2875 50th Street Sacramento, CA 95818. Visitors are always welcome.

Please take a few moments to complete the Membership Information Form enclosed with this letter, select the membership classification that is within your means and return to:

CCHF, P.O. Box 163689, Sacramento, CA 95816.

The Foundation is here for you. Thank you, in advance, for your continued support.

Sincerely,

Sean Hubbert
President

CCHF MEMBERSHIP APPLICATION FORM 2012

Name____ Occupation______________________________

Telephone Number (______) ________________________ Fax (_______) ___________________________

Street Address____

____

City ____________________________________ State________________ Zip Code_____________________

E-mail Address____

( ) I HAVE A BLEEDING DISORDER DATE OF BIRTH_____________

( ) I am the parent of child(ren) with a bleeding disorder

Child's Name ____ DATE OF BIRTH_____________

Child's Name ____ DATE OF BIRTH_____________

( ) I AM A RELATIVE OF A PERSON WITH BLEEDING DISORDER

( ) I AM A PROFESSIONAL TREATER OF THOSE WITH BLEEDING DISORDERS

( ) I AM AN INTERESTED SUPPORTER, BUT HAVE NO BLEEDING DISORDER

I/MY CHILDREN HAVE

( ) Factor VIII Deficiency ( ) Factor IX Deficiency

( ) von Willebrand's Disease ( ) OTHER (specify)_______________________

Treatment Center______________________________________ Primary Physician__________________________

Street Address____

City____ State_________________ Zip Code__________________

MEMBERSHIP CLASSIFICATION

( )	BENEFACTOR	($500 OR MORE)	( )	FAMILY MEMBER	($25)
( )	PATRON	($100)	( )	OTHER	($________)
( )	SUPPORTING MEMBER	($50)	( )	REQUEST WAIVER	($0)