



Narcolepsy Network, Inc.
110 Ripple Lane, North Kingstown, Rhode Island 02852
Toll Free: (888) 292-6522; Tel (401) 667-2523; Fax (401) 633-6567
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Website: www.narcolepsynetwork.org

PROFESSIONAL MEMBERSHIP FORM

(Membership year is July 1st till June 30th of the next year)

Organization/Sleep Center/Name: _____

Street Address: _____

City, State, & Zip Code: _____

Telephone: _____ Fax: _____ E-mail: _____

Web Site: _____

Contact Person: _____ Date: _____

I do do not wish to receive communications from Narcolepsy Network via email.

I would like to receive the quarterly newsletter by _____ surface mail or _____ Members Only Web Access.

(Sleep Center Members: Please provide mailing list - see back of form.)

MEMBERSHIP DUES: _____ **new member** _____ **renewing member** _____ **date**

_____ \$150 Sleep Center _____ \$75 Professional

_____ **DONATION:** I have included an additional donation of \$ _____

_____ **PLEDGE:** I wish to pledge an annual gift of \$ _____ to be paid with the enclosed amount and three (3) more quarterly installments of \$ _____ each. (Reminder notices will be sent).

Please make your CHECK payable to NARCOLEPSY NETWORK, INC. Mail form and payment to:
Narcolepsy Network, Inc. • 110 Ripple Lane • North Kingstown, RI 02852.

All amounts are payable in U.S. DOLLARS by check, money order, or credit card. Checks must be drawn on a U.S. bank. Please call for information. Narcolepsy Network, Inc. (NN) is a 501(c)(3) non-profit organization under IRC Sec 501(c)(3). Any donation over the amount of dues is tax deductible. NN will send a receipt for all donations. An annual report is available upon request.

CREDIT CARD payments accepted. Please provide the following:

Credit card type (please circle): Visa Master Card

CARDHOLDER NAME: _____ Exp. Date: _____

Billing Address: _____

Card Number: _____ Signature: _____

Please complete back of form

The following information is requested so we can provide the applicable member benefits:

MEMBERSHIP CERTIFICATE

Name as you wish it to appear on Certificate of Membership:

I wish to purchase a frame (black leatherette with gold accenting) from Narcolepsy Network

(\$15, including S/H): _____ Yes _____ No

SUPPORT GROUP INFORMATION:

_____ I am interested in starting a narcolepsy support group. Please send me information.

_____ I facilitate the following support group:

Group's Name _____ Contact Person: _____

Telephone (____) _____ Email: _____

Is this support group limited to your patients? Y/N _____ If not, who may participate? _____

_____ I would like our Narcolepsy Support group listed on Narcolepsy Network's website.

GENERAL (check all that apply)

_____ AASM-accredited sleep center.

_____ Board-certified sleep professional

_____ Sleep Researcher

_____ Physician in private practice (Medical specialty _____)

_____ Sleep Center _____ Other Organization _____ Sleep Professional

Which benefits do you value most? _____

Other benefits you would like us to offer _____

Number of Narcolepsy /Hypersomnia patients diagnosed and/or treated per year (estimate) _____

(This number of patient packets will be provided.)

YOU MAY MAY NOT give my name to patients seeking a Sleep Center, physician or other professional through Narcolepsy Network.

I DO DO NOT wish to be listed on Narcolepsy Network's website as a Sleep Center and/or Professional Member. (Note: Sleep Center members will be listed under both categories; Professional members will be listed on the Professional Members page only.)

Sleep Center members only:

Names (for surface mail delivery) or email addresses (if web access is preferred) of Sleep Center staff who wish to receive our newsletter:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(If more space is needed, please continue on a separate sheet and return with this form.)