CENTRAL VIRGINIA
CHRONIC FATIGUE
SYNDROME
AND
FIBROMYALGIA
ASSOCIATION

Education Advocacy Encouragement

POST OFFICE BOX 5733
CHARLOTTESVILLE, VA 22905

PHONE: 434-984-3419
EMAIL: CFSFMA@AVENUE.ORG

Membership Request and Donation Form

Name ____ Phone _____________________

Address____

City, State, Zip____

Email____

Check here if you do NOT wish to be included in a membership roster distributed to members only.

❑ **Annual Membership Dues $15**
❑ I wish to apply for financial hardship. (Note special circumstances on back.)
My income is ___________ per month or __________ per year.

Donations in addition to membership dues are much appreciated. Please give as generously as you can.							
❑ $10	❑ $25	❑ $50	❑ $75	❑ $100	❑ $250	❑ $500	Other ______

Dues __________
Donation __________
Total Enclosed __________

Please pay by check or money order payable to CFS and FM Association.

OPTIONAL—In order to help us serve you better, please complete the following.

What is your diagnosis? (Check all that apply.)

❑ Chronic Fatigue Syndrome
❑ Neurally Mediated Hypotension
❑ Postural Orthostatic Tachycardia
❑ Irritable Bowel Syndrome
❑ Fibromyalgia
❑ Interstitial Cystitis
❑ Hypothyroid (Low)
❑ Other _______________________________________
____
❑ Post-Polio Syndrome
❑ Mitral Valve Prolapse
❑ Hyperthyroid (High)
❑ Arthritis
❑ Lupus
❑ Headaches

Date Received ________
Amount ___________
Check No ___________
Received by __________

Thank you for your support.