Narcolepsy Network, Inc.
46 Union Drive Apt: A212, North Kingstown, Rhode Island 02852
Toll Free: (888) 292-6522; Tel (401) 667-2523; Fax (401) 633-6567
E-mail: narnet@narcolepsynetwork.org
Website: www.narcolepsynetwork.org

PROFESSIONAL MEMBERSHIP FORM

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 **o**r ____ email

MEMBERSHIP DUES: _____ new member _____ renewing member _____ date

____ $175 Sleep Center ____ $85 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. • 64 Union Dr Apt A212 • 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: _____ 3-4 Code: _____

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

($18, 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) _____

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.

Names (for surface mail delivery) or email addresses (if web access is preferred) of Sleep Center staff who wish to receive our newsletter: Professional membership limit of 3. Sleep Center membership limit of 10

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Rev June 2015