



Participant Enrollment

Participant Contact Information	
Name:	
	First (Middle Initial) Last
Address:	
	Street Address Apt. #
	City State Zip
Phone:	
	Home Phone # Cell Phone #
Email:	
	Primary Email Alternate Email

Enrollment information is confidential and will be used for Blood Sisterhood Program purposes **ONLY!**

About You	
Blood Sisterhood Member Org <i>(insert local member org)</i>	
Date of Birth	Month/Date/Year (xx/xx/xxxx)
Bleeding Disorder	<input type="checkbox"/> VWD <input type="checkbox"/> Hemophilia A <input type="checkbox"/> Hemophilia B <input type="checkbox"/> Hemophilia C <input type="checkbox"/> Platelet Disorder <i>(please specify)</i> _____ <input type="checkbox"/> Factor Deficiency <i>(please specify)</i> _____ <input type="checkbox"/> Other <i>(please specify)</i> _____
How Severe?	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Don't Know
Please contact me with information about other Blood Sisterhood/HFA programs.	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate programs/services you'd like to learn more about: <input type="checkbox"/> Online Community <input type="checkbox"/> Webinars <input type="checkbox"/> Other HFA Programs <i>(please specify)</i> _____

Congratulations! Welcome to HFA's Blood Sisterhood Program!!

In appreciation for your participation and commitment to the program, we would like to send you a Blood Sisterhood "Welcome Kit". (Please allow 3-4 weeks for delivery!)

- Yes, please send me a Blood Sisterhood "Welcome Kit"** to address listed above.
- No, DO NOT send a Blood Sisterhood "Welcome Kit" at this time.

All information required for registration to be complete.



Participation & Confidentiality Agreement

Participation

I agree to participate in the HFA Blood Sisterhood Program. As a participant, I understand and agree to attend all HFA Blood Sisterhood activities, to the best of my ability.

I understand and agree that I will be required to complete a survey which may include personal data and information. I understand and agree that information provided in these surveys may be utilized by HFA, in a non-identifiable and confidential manner, in order to provide documentation and data for grant funding and program evaluation purposes.

I understand the need for and I agree to protect the confidentiality of any and all personal information shared by all participants during HFA Blood Sisterhood Activities in which I am involved.

I also understand the importance of all participants feeling comfortable in sharing personal information within a HFA Blood Sisterhood Group.

I agree to maintain the confidentiality of any and all personal information shared by participants.

Photo Release

I authorize the use of photographs or videos for HFA use only

Confidentiality

I understand that HFA wishes to insure the comfort level of participants in sharing information so they can structure the presentations to include their personal information if desired. I understand that Confidentiality is required to be maintained and will be observed in all HFA Blood Sisterhood Activities.

I understand and agree that I will not discuss personal information about my peers learned during any HFA Blood Sisterhood activities. I also agree that I may not discuss any personal information learned with any individual, entity or representatives of any Pharmaceutical Company, HTC, Homecare Provider, Pharmacy or other Healthcare Provider.

Participant Signature

Date

HFA Program Coordinator

Date

All information required for registration to be complete.