



INTERNATIONAL RETT SYNDROME FOUNDATION PARTNERSHIP APPLICATION

Applicant's Name _____

Spouse's Name *(if applicable)* _____

Street _____

City _____ State _____ Zip _____

E-mail(s) _____

Home Phone _____ Work Phone _____

Mobile Phone _____

Occupation _____ Place of Business _____

Please Check Applicable Categories:

- | | | |
|--|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Relative |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Researcher | <input type="checkbox"/> Other |
| <input type="checkbox"/> Teacher/Therapist | <input type="checkbox"/> Care Giver | <input type="checkbox"/> Friend |

First And Last Name Of Individual With RTT:

Date Of Birth _____ Has Diagnosis Been Confirmed? ☐ Yes ☐ No

Date Of Diagnosis _____ Mutation Number _____

Test Mutation ☐ Yes ☐ No Test Results ☐ Positive ☐ Negative

Mother's First And Last Name _____

Father's First And Last Name _____

Physician's Name _____ Physician's Phone Number _____

Partnership Level

☐ Corresponding Partner (Free)
(1 person)

☐ \$30.00 Active Partner
(1 person)

☐ \$40 International Partner
(includes Canada; 1 person)

☐ \$125 Organization/Group Partner
(*5 people)

☐ \$500 Lifetime Partner
(*2 people)

Organization/Group and/or Lifetime Partnerships

Please provide names, addresses and phone numbers of each person below:

| | |
|----------------------------|----------------------------|
| 1. _____ _____ _____ | 2. _____ _____ _____ |
| 3. _____ _____ _____ | 4. _____ _____ _____ |
| 5. _____ _____ _____ | |

Payment Methods (All partnership payments must be in U.S. funds)

Check made payable to **IRSF** for the TOTAL amount of \$ _____

Credit Card ☐ AMEX ☐ MasterCard ☐ Visa

Name (as it appears on credit card) _____

Card Number _____ Security Code _____

Expiration Date _____

Amount \$ _____

Signature _____

Please Check If You Give Permission To

☐ Use your child's photo (please include photo)

☐ Release your contact information to other parents for correspondence

☐ Release your contact information to researchers for study

Additional Information We Should Know _____

How You Can Help In Fundraising _____

Areas Of Interest For Volunteering _____

Please mail to:

International Rett Syndrome Foundation, P.O. Box 706143, Cincinnati, OH 45270-6143

