

Members Details

Title		Full Name	
Address			
Town			
County			
Post Code		Phone no:	

Do you have EDS yourself, if so which type?	
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Sufferers Details (if not member)

Name		Date of Birth	
Type of EDS - if known			

Name		Date of Birth	
Type of EDS - if known			

Are you willing for us to store your details on our computer? (Essential for the smooth running of the Group. All details are kept confidential and are not made available to third parties without your prior written consent.)

Yes	No
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Would you like your details to be made available to Other members in order to promote mutual support?
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Yes	No
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From time to time our Medical Advisory Panel wish to undertake research into EDS. Are you willing for your details to be passed on so that you may have the opportunity of participating?
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Yes	No
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How did you hear about the Support Group?	
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