

Asian Network of Patients' Organisations and Medical Specialists in the Field of Haemoglobin (Hb) Disorders

Membership form A: Patients/Parents

NATIONAL THALASSAEMIA ASSOCIATION DETAILS	
Name of the association:	_____
Contact person:	_____
Email address:	_____
Postal address	_____

	Postal Code _____
City _____	Country _____
Telephone / fax:	_____

The question below is optional for those who wish to state their perspective.

1. What support and/or assistance would you like to receive through TIF's Asian Network and how do you feel you can contribute to this Network?

