European 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 European Network and how do you feel you can contribute to this Network?
