

ThyCa: Thyroid Cancer Survivors Association, Inc.

Membership Application

Please print this application and send it, with your check, money order, or credit card information, to the address listed below.

Mailing address:

ThyCa, Inc.
Membership
PO Box 121563
West Melbourne, FL 32912-1563

Membership dues: ___ 1 year- \$25.00 (US) ___ 2 years- \$45.00 (U.S.) ___ Lifetime-\$225.00 (US)

PAYMENT METHOD: ___ My check or money order payable to *ThyCa* is enclosed

___ Please charge my ___ Visa ___ Mastercard ___ Discover

Card # _____ Exp. _____

Name as it appears on the Card _____

Signature _____

Required Information: (No identifying information will be made known to any person or organization outside of ThyCa)

1. Name: _____

2. Mailing address: _____

Optional Information:

Please provide as much optional information as possible for our records

3. Telephone number: _____

4. Birth date: _____ 5. Sex: _____ 6. E-mail address: _____

7. Are you joining ThyCa as a: ___ Thyroid cancer survivor ___ Caregiver ___ Member of the medical community

Thyroid Cancer Survivors please complete the following:

8. Age at diagnosis ___ 0-9 ___ 10-19 ___ 20-29 ___ 30-39 ___ 40-49 ___ 50-59 ___ 60-69 ___ 70-79 ___ 80+

9. Type of cancer (check all that apply) ___ Papillary ___ Follicular ___ Hurthle ___ Medullary ___ Anaplastic

10. Surgery ___ Partial thyroidectomy ___ Total thyroidectomy ___ Partial followed by completion ___ Neck Dissection ___ Additional surgeries-specify _____

11. Treatment ___ Radioactive iodine ___ How many times? _____ Total millicuries ___ External beam radiation ___ Chemotherapy

12. What type of physicians have you used for your thyroid cancer? (Check all that apply)

___ Endocrinologist ___ General Practitioner ___ Oncologist ___ ENT Surgeon ___ General Surgeon

___ Oncological Surgeon ___ Other-specify _____