



ThyCa: Thyroid Cancer Survivors' Association, Inc.  
www.thyca.org

## Membership Sign-Up Form New Member or Renewal

Please print this form and mail it to the address below with your check, money order, or credit card information. We welcome members living anywhere in the world.

Mailing address:

**ThyCa: Thyroid Cancer Survivors' Association, Inc.**  
**Membership**  
**PO Box 1102**  
**Olney, MD 20832-1102 USA**

Membership dues: \_\_\_ 1 year- \$25.00 (US\$) \_\_\_ 2 years- \$45.00 (US\$) \_\_\_ 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 Contact Information:** (No identifying information or mailing address will be made known to any person or organization outside of ThyCa)

1. Name: \_\_\_\_\_

2. Mailing address: \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_

### Optional Information:

Please provide as much optional information as you choose.

3. Telephone number: \_\_\_\_\_

4. E-mail address: \_\_\_\_\_ 5. Birth year: \_\_\_ 6. Sex: \_\_\_

7. Are you joining ThyCa as a:

\_\_\_ Thyroid cancer survivor \_\_\_ Caregiver \_\_\_ Health Care Professional \_\_\_ Other \_\_\_\_\_

### Optional: 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 thyroid cancer (check all that apply) \_\_\_ Papillary \_\_\_ Follicular \_\_\_ Hurthle  
\_\_\_ Anaplastic \_\_\_ Medullary: \_\_\_ Sporadic \_\_\_ Familial \_\_\_ Other details \_\_\_\_\_

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 \_\_\_ Other: specify \_\_\_\_\_

12. What type of physicians have you used for your thyroid cancer? (Check all that apply)  
\_\_\_ Endocrinologist \_\_\_ General or Family Practitioner \_\_\_ Oncologist \_\_\_ ENT or Endocrine Surgeon  
\_\_\_ General Surgeon \_\_\_ Oncological Surgeon \_\_\_ Other: specify \_\_\_\_\_

Thank you very much for your wonderful support.