

*in*Motion Subscription Application

PERSONAL INFORMATION

Name _____ Account # (if Applicable) _____

Organization _____

Address _____

City _____

State _____ ZIP _____

Phone _____

E-Mail _____

Male Female U.S. Veteran: Yes No

Marital Status: _____ Date of Birth: _____

Ethnicity: African American Asian Caucasian

Hispanic/Latino Other: _____

Are you a(an) Amputee, Friend, Caregiver and/or

Professional? If Professional, what field? _____

If Amputee, when was your amputation? _____

Limb Loss Type: Above-Knee Below-Knee Above-Elbow

Below-Elbow Other: _____

Site: Left Right Bilateral Other: _____

Amputation Cause: Cancer Congenital Diabetes

Vascular Trauma: _____

SUBSCRIPTION CATEGORIES

United States:

\$24.00/Year \$ _____

Outside of the U.S.:

\$48.00/Year \$ _____

Total: \$ _____

METHOD OF PAYMENT

Check Enclosed

Credit Card Information Enclosed (Please ensure that verification code and signature are included. If credit card belongs to someone other than the subscriber, please include a phone number and address where cardholder can be reached.)

Make checks/money orders payable to:

Amputee Coalition
900 E. Hill Ave., Ste. 205
Knoxville, TN 37915
Fax: (865) 525-7917
amputee-coalition.org

Credit Card: American Express MasterCard Visa

Name on Card _____

Address of Cardholder (if different than subscriber) _____

City _____

State _____ ZIP _____

Telephone _____

Card # _____ Verification Code _____ Exp. Date _____

Signature _____