

Antelope Valley Ostomy Support Group

APPLICATION FOR MEMBERSHIP

Name: _____

Address: _____

Phone: _____

Date: _____

Type of ostomy: _____

If you would like to join the [Antelope Valley Ostomy Support Group](#), please send this application with a check **for yearly dues of \$10.00** (dues can also be paid at the meetings) to:

AV Ostomy Group
Lancaster Chapter
6510 West Avenue L
Lancaster, CA 93536

Dues support our local Ostomy Support Group and include subscription to our ostomy newsletter published prior to the meetings every month.