

## international children's anophthalmia network

Check one:		ual Associate ual Donation)					
Name:							
Address:							_
City:	v: State			:Zip:			
Daytime Pho	ne Number	:		<del></del>			
Name of fami Date of birth:		with Anophtha	almia or Mic	rophthalmia:			_
**Professiona	al Affiliation	:					_
Father's Nam (Complete address	16 if not same as al	_ Mother's	Mother's Name				
			Address				
City	State	Zip	_ City	Si	tate	Zip	
	ANOPHTH	IALMIA/MICRO		IA REGRIST required to join <b>ica</b> l		LICATION	
about the prea description The goal of identify all the recurrence riverguest that have any specontact Adel	egnancy his of the affe the A/M Ro he syndror sk to famil you give pe ecific ques e Schneide	ophthalmia (A/litory including pected individual egistry is to demes associate lies planning formission to restions regardiner, Director of delphia at (215)	possible expals eye find etermine a under the with A/M urther child view medicates the purpose A/M Regist	oosure during ings and any more accura I and to try ren. As part al records of ose and objects	y the property associate incide of the inception of the ective of the property of the inception of the incep	regnancy, faciated birth dence of A/l provide mo Registry, v dividual with of the Regis	mily history, differences. M, to better accurate we will also A/M. If you stry, please
If you would the A/M Regi		plete the A/M in the mail.	Registry, ple	ease indicate	below	if would like	e us to send
` '	ase send r Name:	ne the A/M Remote the A/M Re	gistry to the	address bel			_
	City:		PA		Zip:_		<del></del>

( ) I am not interested in participating in the A/M Registry