*Date of Registration:* _____ *Client ID#:* _____

# Ashland County Cancer Association Registration Form

Name: _____ Phone Number: _____

Date of Birth: _____ Twp.: _____

Address: _____ City & Zip: _____

Email: _____

Would you like to receive our ACCA newsletter? _____ ◻ Mail or ◻ Email

Support Person: _____ Relationship: _____

Address: _____ City & Zip: _____

Phone Number: _____

***Medical Information:***

Family Doctor: _____ Oncologist: _____

Cancer Treatment Center: _____

Current Cancer Diagnosis: _____

Past Cancer Diagnosis: _____

***How did you hear of the Ashland County Cancer Association?***

◻ Friend ◻ ACCA Client ◻ Family ◻ Social Media ◻ Physician _____

◻ Event/Fundraiser_____ ◻ Other _____

***The following demographic information is REQUIRED but is not used to determine eligibility. All Ashland County cancer patients are eligible to receive services offered by the Ashland County Cancer Association regardless of their income status.***

Number of People in Household: _____ Annual Income: _____

Employment Status: ◻ Employed ◻ Unemployed ◻ Retired ◻ Disabled

Veteran: ◻ Yes ◻ No Insurance: ◻ Yes ◻ No Medicare: ◻ Yes ◻ No ◻ Part D Amish: ◻ Yes ◻ No

Ethnicity: ◻ Caucasian ◻ African American ◻ Hispanic ◻ Unknown ◻ Other _____

Do you need help with other services? _____

***Questions/Submit Registration Form:***

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Fax: 419-281-5743 | Office: 419-281-1863