MDA Peer Connections

We invite you to take advantage of the sharing that is possible through talking with others in similar situations.

If you are interested, please complete the form below and return it to MDA at: resourcecenter@mdausa.org.

Name

Address

City State ZIP

Phone Email

Date of Birth

Diagnosis

Parents or Spouse

Interested in connecting with/by:

Please select all that apply (please know that we will narrow our search based on the specifications provided, but cannot guarantee a good fit based on selected specifications).

- ☐ Clients/families with individuals with the same diagnosis
- ☐ Clients/families with any MDA diagnosis
- ☐ Clients/families in my geographical vicinity (~45 miles)
- ☐ Clients/families within driving range (2 hours or less)
- ☐ Clients/families any distance (other states, etc.)
- ☐ Clients/Families interested in Gene Therapy
- ☐ Email
- ☐ Phone
- ☐ In-person
- ☐ Additional Comments

I hereby authorize MDA to release my name, address, telephone number, e-mail, birth date, parent's/spouse's name, and diagnosis to other individuals who have joined the MDA Peer Connections. I further release MDA, its officers, employees, agents, chapters, assignees, licenses, and cooperating entities, their representatives, heirs, administrators, successors and/or assigns from any claims which may arise from my taking part in the MDA Peer Connections. I further understand that I may withdraw my name from future distributions upon written notice to the MDA office.

Signature _____

Signature of parent or legal guardian* (if under 18 years of age)

If you have any questions or concerns regarding the MDA Peer Connections, please call MDA at (800) 572-1717.

** I affirm that I am the parent/legal guardian of the above-named individual and that I have full authority to authorize his/her participation in the above-referenced MDA Peer Connections.*