THE LAM FOUNDATION
A BREATH OF HOPE

LAM Regional Meeting Registration Form

Name: _____

Email: _____

Phone: _____

Address: _____

Are you a? (Circle one): LAM Patient Friend Professional Family (specify relationship):

Contact Preference (Circle all that apply): Email Mail Phone Do Not Contact

Please check one of the below boxes:

- ☐ I give my permission to The LAM Foundation to share my information with other individuals with LAM or LAM families/caregivers who are registered with The LAM Foundation.

- ☐ I do not give my permission to The LAM Foundation to share my information outside of official representatives of The LAM Foundation.

Signature: _____