

TWINSIGHT
A Mothers of Twins Club
MEMBERSHIP FORM

New Member

Renewal

Name _____

Spouse _____

Address: _____

City and Zip: _____

Zip +4: _____

Home Phone: _____

Work Phone _____

E-mail address: _____

Cell Phone _____

Can we email your newsletter to you?
(hard copy would not be mailed)

Yes _____ No* _____

Member Birthday: _____

Anniversary: _____

Twins names: _____ and _____

Twins Birthdate: _____

Twin type (Ident, Frat, Unk) _____

Child's name: _____

Birthdate: _____

Child's name: _____

Birthdate: _____

Child's name: _____

Birthdate: _____

Child's name: _____

Birthdate: _____

Child's name: _____

Birthdate: _____

Are you interested in serving on the Twinsight board? Yes No

New Members:

Please indicate how you learned about Twinsight: _____

Please complete this form, enclose your check for \$35.00 yearly dues payable to Twinsight, and
mail to: *Stacy Abel 1046 Sheridan Rd. Deerfield, IL 60015*

*Emailed copy of newsletter is included in your dues. A surcharge of \$10.00 will be applied for requesting a paper mailed newsletter.