



Membership Application

I want to be a part of PossAbilities! Please process my application today!

Membership Categories

- New Member Support Member Address Change
 Male Female

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone (____) _____

Email _____

My Disability

Please list your disability or disabilities below.

My signature verifies membership acceptance to join PossAbilities and gives you permission to take photographs of me or my dependent named above to serve the best interests of Loma Linda University Medical Center or any of its divisions, schools, or programs or will be in the public interest.

Signature _____ Date _____

Enclose membership application in an envelope and mail to:

PossAbilities
25333 Barton Road
Loma Linda, CA 92354