



Please return to:
Ostomy Association of Boston
30 Speen Street
Framingham, MA 01701-1800
508-270-4656

Satellite	_____
Date	_____
Total Attendance	_____

Please Print Clearly:

Please check all Applicable boxes.

Name _____	<input type="checkbox"/> New Ostomy	<input type="checkbox"/> Continent Ileostomy	<input type="checkbox"/> OAB Member	Comments: _____ _____
Address _____	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Ileoanal Reservoir	<input type="checkbox"/> NON OAB Member	
City, State & Zip _____	<input type="checkbox"/> Ileostomy	<input type="checkbox"/> Continent Urostomy	<input type="checkbox"/> New To This Meeting	
Email address _____ Phone: _____	<input type="checkbox"/> Urostomate	<input type="checkbox"/> Family of person with Ostomy		
Name _____	<input type="checkbox"/> New Ostomy	<input type="checkbox"/> Continent Ileostomy	<input type="checkbox"/> OAB Member	Comments: _____ _____
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