2024 Annual Members' Meeting, April 19th & 20th
The Mermaid Event Center
2200 Mounds View Boulevard
Mounds View, MN 55112

HEMOPHILIA FOUNDATION OF MINNESOTA/DAKOTAS

Hotel Reservation Deadline: April 5, 2024
Event Registration Deadline: April 14, 2024
Remit form to: info@hfmd.org

ALL INFORMATION IS REQUIRED

Your Name: ____________________ Phone: ____________________

Full Address: ____________________

Email: ____________________

Add immediate family members who will be attending. Please provide ages of children.

Name	Age	Check Applicable Box	Child Care?
		❑ Bleeding Disorder ❑ Parent ❑ Sibling	❑ YES ❑ NO
		❑ Bleeding Disorder ❑ Parent ❑ Sibling	❑ YES ❑ NO
		❑ Bleeding Disorder ❑ Parent ❑ Sibling	❑ YES ❑ NO
		❑ Bleeding Disorder ❑ Parent ❑ Sibling	❑ YES ❑ NO
		❑ Bleeding Disorder ❑ Parent ❑ Sibling	❑ YES ❑ NO
		❑ Bleeding Disorder ❑ Parent ❑ Sibling	❑ YES ❑ NO
		❑ Bleeding Disorder ❑ Parent ❑ Sibling	❑ YES ❑ NO

How many adults and children will be attending each meal?

Friday Dinner	Adults _____	Children _____
Saturday Breakfast	Adults _____	Children _____
Saturday Lunch	Adults _____	Children _____

Please indicate any dietary allergies and let us know which family member it applies to.

____

____

____

HFMD has reserved a small block of rooms at the connected hotel and HFMD WILL MAKE ALL ROOM RESERVATIONS!
This is on a first come, first serve basis. Please send in your registration form to HFMD prior to April 5th to secure your hotel room.
(check-in time: 4:00 p.m. check-out time: 11:00 a.m.)

☐ **No Hotel Room Needed**

☐ I will cover the cost of my hotel stay by sending a check payable to HFMD for $173.43. *(or fill out CC info below)*

☐ **I would like HFMD to cover the cost of my standard room for Friday, April 19th.**

☐ We are traveling over 150 miles one way; I would like HFMD to cover the cost of my standard room for Fri & Sat.

☐ I would like to donate $ ________ towards my hotel by: ☐Mailing a check ☐Charge my Card listed below

☐ I request mileage reimbursement *(available for those living over 150 miles from the event.)* Maximum reimbursement is $75

☐ Enclosed is the registration fee (*check one*): ☐ $20.00 per person; ☐ $40.00 for a family.

☐ **Please waive the registration fee.**

Mail this form with or without a check or credit card payment information to:

HFMD • 750 South Plaza Drive • Suite 207 • Mendota Heights, MN 55120 • 1-800-994-4363 or 651-406-8655

Name on Card: ____________________ Zip: __________ Amount: $__________

Card Number: ____________________ Expiration Date: _____ / _____ Security Code: _______