

Mission and Membership Criteria



Mission The mission of the MDS Alliance is to better serve the MDS patient and caregiver community globally

Vision Our vision is optimal care for all MDS patients worldwide.

Organization & Structure

Leadership Group - A group of six MDS patient advocacy organizations to provide leadership and direction to the MDS ALLIANCE.

The initial Leadership Group members



Membership

➤ **Regular members:** These are established nonprofit/non-governmental organizations which have been in experience for at least three years. They must be focused on meeting the needs of patients and caregivers living with MDS and meet the membership criteria below.

➤ **Provisional members:** These are new or start-up nonprofit /non-governmental organizations that are less than three years old and/or do not meet all of the membership criteria.

Additional connections

➤ **Associates:** Professional organizations with whom we partner. These are groups that support the mission and vision of the MDS ALLIANCE, but do not have MDS as a primary focus OR are regional or local MDS organizations.

➤ **Supporters:** Pharmaceutical companies willing to support our mission and vision.

Membership Criteria

Application and Review

- Application for MDS ALLIANCE membership shall be submitted to the Leadership Group.
- Review of the application will be completed within 30 days of receipt of the application.
- In order to insure that membership criteria are being maintained, each group will be asked to submit a renewal application every two years.
- Membership may be revoked or not renewed by the Leadership Group if a member is found to be significantly out of compliance with these membership criteria.

Groups must be:

- A non-profit or non-governmental organization certified/chartered or registered in their home country
- A permanent/ongoing entity
- National or international in scope
- Formed primarily for the needs of people living with MDS and support the mission, vision and programs of the MDS-A
- Willing and able to engage in the activities of the Alliance
 - Represent MDS-A in their country
 - Share their experience and expertise
 - Link to the MDS-A website
- Promote MDS-A at conferences
- Able to insure that all patient education materials and information have been properly reviewed and approved by appropriate medical professionals

www.mds-alliance.org

Membership Application Form



If you prefer to print the form, please complete and mail to:

MDS ALLIANCE
c/o AA&MDSIF
100 Park Avenue
Suite 108
Rockville, MD 20850
USA

Membership in the MDS ALLIANCE is free of charge.
 Please send the completed form to info@mds-alliance.org.

1. Your Organization

Name of Organization: (in English)	
Name of Organization: (in your national language)	
Disease Area:	
Geographic Focus :	<input type="checkbox"/> Local <input type="checkbox"/> National
Website:	
E-Mail Address Executive / office	
Telephone Number (incl. country code):	
Fax Number: (incl. country code):	
Organization Chair/President	
E-mail Address Chair / President	

2. Principal Contact Person

Name:	
Position:	
Direct E-mail Address:	
Direct Telephone:	
Direct Fax:	

How many MDS patients, families and caregivers does your organization approximately represent?

3. English Language Summary of Your Organization's Goals and Activities

Activities:

- Patient meetings
- Patient telephone helpline
- Information packs
- Attendance at congresses
- Other:

4. Type of Membership You Are Applying for (please mark the box with an "X")

Please make sure you meet the MDS ALLIANCE membership criteria
(<http://www.mds-alliance.org>)

- Regular Member
- Provisional Member

5. Existing Memberships (please mark the box with an "X")

Is your organization already a member of other alliances or coalitions?

- No
- Yes -If yes: Please provide a list of organizations of which your organization is a member.

Does Your Organization Focus on Diseases in Addition to MDS?

- No
- Yes - If yes: Please list

Does Your Organization have a medical advisor who reviews the contents of your website for medical correctness?

- No
- Yes - If yes: Please list his/her name, contact details and email:

6. Confirmation and Signature

I hereby confirm that the information given above is accurate, and that my organization is eligible to be a Member of the MDS ALLIANCE as defined above.

Signed:

Name and Position:

Place / Date: