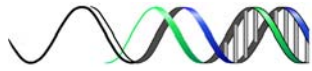


# Booklet Order Form



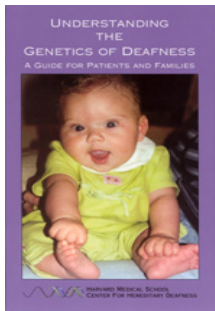
HARVARD MEDICAL SCHOOL  
CENTER FOR HEREDITARY DEAFNESS

HPCGG, 65 Landsdowne Street, Cambridge, MA 02139, Phone: 617-768-8521, Fax: 617-768-8513, hearing@hms.harvard.edu

These booklets are provided by the Harvard Medical School Center for Hereditary Deafness, with support from the Harvard Medical School-Partners HealthCare Center for Genetics and Genomics (HPCGG). Due to limited resources, we are now charging for orders of 5 booklets or more. To place an order, complete this order form and fax or mail it to the address above. If you are not able to afford the cost of the booklets, please e-mail the Center, describing your needs and how you will use the booklets, and we will consider donating the booklets free of charge.

## BOOKLET PRICES

### Understanding the Genetics of Deafness: A Guide for Patients and Families



Quantity	Price
1-2	Free
5	\$10
10	\$20
15	\$30
25	\$45
50	\$90
75	\$135
100	\$175

### Common Causes of Hearing Loss: For Patients and Families



Quantity	Price
1-2	Free
5	Free
10	\$5
15	\$7
25	\$10
50	\$20
75	\$30
100	\$36

## ORDER & PAYMENT

Item	Quantity	Price
Understanding the Genetics of Deafness		\$
Common Causes of Hearing Loss		\$
	<b>TOTAL</b>	<b>\$</b>

**Billing Address\***  same as shipping  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State Zip: \_\_\_\_\_

\*Used for reference only. You will not receive a bill.

### Payment for 5 or more booklets:

- Credit card information: VISA, MasterCard, American Express (circle one)  
 Number \_\_\_\_\_ 3-digit security code \_\_\_\_\_ Exp. date \_\_\_\_\_
- Personal check (please make payable to "HPCGG")
- Money order (please make payable to "HPCGG")

## SHIPPING INFORMATION

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ \*FedEx Account #: \_\_\_\_\_  
 City, State Zip: \_\_\_\_\_ Country: \_\_\_\_\_

\*Shipping fees using media mail (2-9 days) are included in the prices above. For faster service, please provide a FedEx account number.

## YOUR AFFILIATION

Please choose role that best defines you:

- |  |   |
|--|---|
| <input type="checkbox"/> Person with hearing loss                        | <input type="checkbox"/> Speech and language pathologist                  |
| <input type="checkbox"/> Parent or relative of someone with hearing loss | <input type="checkbox"/> Early intervention specialist                    |
| <input type="checkbox"/> Audiologist                                     | <input type="checkbox"/> Affiliated with a support group for hearing loss |
| <input type="checkbox"/> Otolaryngologist/ENT                            | <input type="checkbox"/> Educator   |
| <input type="checkbox"/> Geneticist                                      | <input type="checkbox"/> Researcher                                       |
| <input type="checkbox"/> Genetic Counselor                               | <input type="checkbox"/> Student  |
| <input type="checkbox"/> Pediatrician                                    | <input type="checkbox"/> Other: _____                                     |
| <input type="checkbox"/> Newborn hearing screening program               |   |