

HALIFAX REGIONAL CEREBRAL PALSY ASSOCIATION

2009 MEMBERSHIP APPLICATION

NAME: _____

ADDRESS: _____

PHONE NO: _____

E-MAIL: _____

NAME OF PERSON WITH CP (if not a member above)

BIRTH DATE (OPTIONAL): _____

Month Day Year (optional)

IF CHILD, AGE: _____

WHEELCHAIR: YES ___ NO ___

TO BE CALLED RE: MEETINGS _____

SPECIAL OCCASIONS _____

MEMBERSHIP FEES:

\$10.00 SINGLE _____

\$20.00 HOUSEHOLD (Includes 4 people at the same address) _____

\$30.00 HOUSEHOLD (Includes 5 or more people at same address) _____

PLEASE MAIL APPLICATION WITH APPROPRIATE FEE TO:

HALIFAX REGIONAL CEREBRAL PALSY ASSOCIATION

P.O. BOX 33075, QUINPOOL POSTAL OUTLET

HALIFAX, NOVA SCOTIA

B3L 4T6