

**HALIFAX REGIONAL CEREBRAL PALSY ASSOCIATION**

**2009 MEMBERSHIP RENEWAL APPLICATION**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PHONE NO: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

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

\_\_\_\_\_

BIRTH DATE (OPTIONAL): \_\_\_\_\_

Month Day Year

IF CHILD, AGE: \_\_\_\_\_

WHEELCHAIR: YES \_\_\_ NO \_\_\_

TO BE CALLED RE: MEETINGS \_\_\_\_\_

SPECIAL OCCASIONS \_\_\_\_\_

**MEMBERSHIP FEES:**

\$10.00 SINGLE \_\_\_\_\_

\$20.00 HOUSEHOLD (Includes 2-4 people at the same address) \_\_\_\_\_

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

PLEASE MAIL APPLICATION by **JAN 31, 2009** WITH APPROPRIATE FEE TO:

**HALIFAX REGIONAL CEREBRAL PALSY ASSOCIATION**

**P.O. BOX 33075, QUINPOOL POSTAL OUTLET**

**HALIFAX, NOVA SCOTIA**

**B3L 4T6**

**If not received by January 31, 2009, it will be assumed  
you no longer wish to be a member of our Association**