

Membership Form

Primary – Mr / Mrs / Miss / Ms

Additional – Mr / Mrs / Miss / Ms

Last Name _____

First Name _____

Address _____

City _____

Postal Code _____

Phone (H) _____

Phone (H) _____

(B/Cell) _____

(B/Cell) _____

E-mail _____

E-mail _____

Occupation _____

Occupation _____

Employer _____

Employer _____

RELATIONSHIP

I am/We are parent(s)/guardian(s) of a person with sb and/or h adult with sb and/or h interested individual

Name of Individual w/condition _____ Date of Birth _____

Spina Bifida Spina Bifida Occulta Spina Bifida & Hydrocephalus Hydrocephalus

Adult Onset Hydrocephalus Normal Pressure Hydrocephalus Other _____

MEMBERSHIP OPTIONS *Memberships are valid for one year and will be renewable on the anniversary date.*

Individual \$25

Family \$40

I wish to become a member, but am unable to pay dues at this time.

In addition to membership dues, I wish to make a donation in the amount \$_____

METHOD OF PAYMENT

Cheque (payable to Hydrocephalus Canada) Visa MasterCard American Express

Card# _____ CVV# _____ Expiry Date _____

Signature _____

Please send me more information on the following:

- | | | | | |
|--|--|--|---------------------------------------|--|
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Folic Acid | <input type="checkbox"/> Education | <input type="checkbox"/> Fundraising |
| <input type="checkbox"/> Parent Issues | <input type="checkbox"/> Adult Issues | <input type="checkbox"/> Youth Issues | <input type="checkbox"/> Publications | <input type="checkbox"/> Monthly Giving Club |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Scholarship Program | <input type="checkbox"/> Library Information | <input type="checkbox"/> Volunteering | |

Member Signature _____

Date _____