

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 or three years and will be renewable on the anniversary date.*

Individual Dues: 1 year = \$20.00 3 years = \$50.00
 Family Dues: 1 year = \$30.00 3 years = \$75.00
 Professional Dues: 1 year = \$30.00
 Associated Group (non-profit) Dues: 1 year = \$30.00
 Corporate Dues: 1 year = \$60.00

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# _____ Expiry Date _____

Signature _____

Please send me more information on the following:

Spina Bifida Hydrocephalus Folic Acid Education Fundraising
 Parent Issues Adult Issues Youth Issues Publications Monthly Giving Club
 Latex Allergy Scholarship Program Library Information Volunteering

Member Signature _____

Date _____