Membership Form

Primary – Mr / Mrs / Miss / Ms

Last Name _____

First Name _____

Address _____

_____

_____

City _____

Postal Code _____

Phone (H) _____

(B/Cell)) _____

E-mail _____

Occupation _____

Employer _____

Additional – Mr / Mrs / Miss / Ms

_____

_____

_____

_____

_____

_____

Phone (H) _____

(B/Cell) _____

E-mail _____

Occupation _____

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:

☐ 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**

Send to: Hydrocephalus Canada, 16 Four Seasons Place, Suite 111, Toronto, ON M9B 6E5 or go online at www.hydrocephalus.ca/get-involved/become-a-member

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