MEMBER APPLICATION

Type of Membership

_____ **Family/Individual - $10.00**
_____ **Business/School/Association - $25.00**

New Membership: ☐ Renewal: ☐ Year of Membership: 2016 / 2017
(September to August)

Name: _____

Address: _____

City/Town: _____ Province: ___ Postal Code: _____

Email address: _____

Phone #: Home_____ Work _____ Cell _____

Name of family member with cerebral palsy (if applicable)

_____Male ___ Female ___ Date of birth _____

I consent for The Cerebral Palsy Association of MB (CPAM) to use my mailing address and phone number for the purpose of informing me about upcoming events & activities, to distribute the newsletter or to mail me information regarding Cerebral Palsy or the association. I understand that CPAM will never sell, rent or distribute my personal information. I may withdraw consent at any time with written notice.

_____ _____
Signature Date

Make a donation, in addition to membership, in the amount of $_____

$25 $50 $100 $200

(Tax receipts will be issued for donation of $10 or more)
Please make Cheques payable to:

Cerebral Palsy Association of MB
903 – 213 Notre Dame Ave Winnipeg, MB R3B 1N3
Website www.cerebralpalsy.mb.ca
Email office@cerebralpalsy.mb.ca
Phone 204-982-4842
Fax 204-982-4844

Office Use:
Date
Amount Received $
Receipt #
Tax Receipt #
Payment type:

You can renew online Go To http://www.cerebralpalsy.mb.ca/membership.htm