



MEMBER APPLICATION

Type of Membership

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

New Membership:

Renewal:

Year of Membership: 2017 / 2018
(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>