COMOX VALLEY HEALTHCARE FOUNDATION

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MEMBERSHIP FORM

NAME_____DATE_____

SIGNATURE_____

ADDRESS STREET

CITY POSTAL CODE

PHONE (Home)_____(Business)_____

E-MAIL_____

Membership (tax-creditable)
Any individual who subscribes to the purposes of the Foundation and makes a donation of at least $25.00 to the Foundation each year, is eligible and may choose to become a member of The Foundation.

‡_____ I have enclosed a cheque or charge my credit card

__Visa
__Mastercard
Card #:
Expiry Date:
Signature:

Members are entitled to attend the annual General Meeting (AGM) of the Foundation, and are entitled to receive Foundation updates.

Note: Members must notify The Foundation when they no longer wish to be a member

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