



Chemainus Health Care Foundation

APPLICATION for MEMBERSHIP

Please Note: The Foundation seeks your membership as an expression of your support and interest in the goals of the Chemainus Health Care Foundation. Your membership in the Foundations does not require that you make a donation to the Foundation.

Please print

Name: _____

Address: _____

Phone #: _____

E-mail _____

I, _____, (signature)

make application for membership in the Chemainus Health Care Foundation

Date: _____

Please mail your application to:

Chemainus Health Care Foundation
Box 462
Chemainus, BC
V0R 1K0

THANK YOU FOR YOUR SUPPORT