



APPLICATION FOR MEMBERSHIP

PLEASE PRINT CLEARLY

Name: _____

Address: _____

Postal Code: _____ Telephone #: (____) _____

Membership is from December 1st to December 1st
Please submit the proper amount depending in which month you are joining

Dec \$30.00	Jan \$27.50	Feb \$25.00	Mar \$23.50	Apr \$20.00	May \$17.50
June \$15.00	July \$12.50	Aug \$10.00	Sept \$7.50	Oct \$5.00	Nov \$2.50

Donation: () \$ _____ I would like a Tax Receipt ()

Languages in which you are fluent: _____

Type of Ostomy: () Ileostomy () Colostomy () Urostomy

() Other _____

Year of Birth: _____ Year of Surgery: _____

I would like to help with: Visiting patients _____ Newsletter _____

Educating Community _____ Committee/Board of Directors _____

No one will be refused from attending meetings due to inability to pay annual dues.

Mail cheques or money orders with this completed form to:

OSTOMY TORONTO
Suite # 501, 344 Bloor Street W, Toronto, ON M5S 3A7

Charitable #11907 1009 RR0001

Revision Date: Sept.17 '04