

# APPLICATION FOR MEMBERSHIP

PLEASE PRINT CLEARLY

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

POSTAL CODE \_\_\_\_\_ TELEPHONE \_\_\_\_\_

MEMBERSHIP IS \$30 FROM December 1st to November 30<sup>th</sup>

DONATION:\$\_\_\_\_\_ I WOULD LIKE A TAX RECEIPT ( )

( ) I WILL ACCEPT AN ELECTRONIC COPY OF THIS  
NEWSLETTER, IN LIEU OF A PRINTED ONE.

EMAIL ADDRESS \_\_\_\_\_

Languages in which you are fluent: \_\_\_\_\_

Type of Ostomy:

( ) Ileostomy ( ) Colostomy ( ) Urostomy ( ) Other

Year of Birth \_\_\_\_\_ Year of Surgery \_\_\_\_\_

No one will be refused attendance to meetings due to the inability to pay dues

Mail Cheque or Money order along with this completed form to:

**OSTOMY TORONTO**  
SUITE 501, 344 BLOOR STREET WEST, TORONTO ON M5S 3A7  
Tel 416 596 7718 Toll free 1 866 285 5948 Fax 416 596 8250

Website: [www.ostomytoronto.com](http://www.ostomytoronto.com) Email: [info@ostomytoronto.com](mailto:info@ostomytoronto.com)

CHARITABLE # 11907 1009 RR0001