



MEMBER INFORMATION

Last Name: _____ *DOB MM/DD/YYYY: __ / __ / __*)
 First Name: _____ F M
 Address: _____
 City: _____ Province: _____ Postal Code: _____
 Phone: (H) _____ (W) _____
 E-Mail Address: _____

OFFICE USE ONLY Date Received:
Member # :
Initials:

FAMILY MEMBER WITH CEREBRAL PALSY

Name: _____ Phone: _____
 Address (phone, email if different from above): _____

I WOULD LIKE TO RECEIVE THE FOLLOWING INFORMATION FROM CPANL

Newsletter Programs & Services Volunteer Special Events Donations

Membership is \$5.00 per individual or \$10.00 per family.

Please consider a gift when completing this form.

Individual (\$5.00)

Family (\$10.00)

I would like to make a donation to the CPANL for the following amount

\$25 \$50 \$100 \$250 Other _____

Cheque enclosed

An official donation receipt will be issued for income tax purposes.

Mail To:

PO Box 515
 Centennial Square
 Mount Pearl, NL
 A1N 2W4

**Your support for the Cerebral Palsy Association of
 Newfoundland and Labrador is greatly appreciated.**