

MEMBERSHIP form



Help for today, Hope for tomorrow.

**Suggested Annual Donation
for Family Membership \$30**

*Membership fees are
allocated to
family support.

Payment Method

Cheque

Money Order

VISA

MasterCard

Amount enclosed or to be
charged \$ _____

Credit Card #

Expiration Date:

Name on card:

Signature:

Family Name _____

E-mail _____

Family Address _____

City, Prov., Postal Code _____

Home Phone _____

Work Phone _____

Mobile Phone _____

Mother/Wife/Guardian _____

Address if not same as above _____

Phone if not same as above _____

Father/Husband/Guardian _____

Address if not same as above _____

Phone if not same as above _____

Relationship to affected person _____

Affected person's name _____

M / F Date of birth _____

SMA Type 1, 2, 3, 4 Date of Diagnosis _____

Current Status _____

Date of death (if applicable) _____

Other persons NOT affected by SMA (siblings, children, parents)

Name _____ M / F DOB: _____

Name _____ M / F DOB: _____

Name _____ M / F DOB: _____

Name _____ M / F DOB: _____

May we add your name/address to our family contact list? Y / N

Return to **CURE Canada Membership**, #103 - 7134 Vedder Road, Chilliwack, B.C. Canada V2R 4G4
Or FAX to (604) 824 - 1363