Count Me In! I want to support Momiji, so I'll show my commitment by being a member!

Name of Member

Name of Member #2 (For couple memberships only)

Address

City Postal Code

Phone ☐ Cell ☐ Home

Email Address (I consent to correspondence via e-mail)

Annual Fee: ☐ Individual $50 ☐ Couple $80

Membership Fee:

Donation (optional):

Total:

A tax receipt will be issued for donations of $20 or more.
Membership fees are non-receiptable.

Paid by ☐ Cash
☐ Cheque payable to "*Momiji Health Care Society*"
☐ VISA
☐ MasterCard

Credit Card#:

Expiry Date: CVV#:

Signature:

For Office Use: ☐ New Membership ☐ Renewal
Membership Number:
Expiry Date:
Date Mailed:

CRA Registration Number 107716623-RR0001