2019/20 MEMBERSHIP APPLICATION

Date:

Name (PRINT CLEARLY):

To ensure the confidentiality and safety of all of our members, please give us contact information, if any, that you wish us to use:

Mailing Address & Contact Information (as applicable)

Street No. & Name: Unit:

City: Province: Postal Code:

Phone No.: Fax No. (if applicable):

Email:

MEMBERSHIP

- ☐ **Yes!** I'd like to become a member. Enclosed is my membership fee of $10.00.
- ☐ **Yes!** I am a current BSCC volunteer and would like to become a member (no fee).

DONATIONS (optional)
Charitable tax receipts are issued for donations $10 and over.
To help more women and their children live their lives free from violence, I would also like to make a donation of:

$10 $25 $50 $75 Other $ ________.

PAYMENT INFORMATION
Amount enclosed: Membership Fee $_________ + Donation $__________ = $____________

Cheque enclosed (payable to the Barbra Schlifer Commemorative Clinic)
Cash
VISA MASTERCARD AMEX

Name on Credit Card:

Credit Card Number: Expiry Date (mm/yy):

Signature: CVV

Date:

Please return the completed application form to the Schlifer Clinic.
By mail: 503 – 489 College St. Toronto, ON M6G 1A5. Or if you are paying by credit card you may also return it by fax: 416-323-9107 or by e-mail: