**Member Application Form**

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| --- | --- | --- |
| **Surname** | **First Name** | **Middle Name** |
| **Full Mailing Address** |  | |
| **Email Address** |  | |
| **Indigenous Nation or Community (if applicable)** |  | |
| **Employer & Title (optional)** |  | |
| **Date of Birth (MM/DD/YYYY)** | **Shirt size (unisex)** | **Phone Number** |

**Please list any accessibility needs you may have to fully participate**

**(include food allergies, disabilities, and other supports needed):**

**Please check any VAHS programs/services that you are (or have been) a part of:**

Primary Care Clinic (Medical Clinic)  Dental Clinic  Cultural/Elders Program

Indigenous Early Years  Other:

**Signature and Consent**

I,                           **(full name),** an adult person whose full contact information is listed above, do hereby apply for general membership of Vancouver Aboriginal Health Society, as per the Society’s By-Laws. On becoming a member, I commit to upholding the Society’s Constitution, By-Laws, and Confidentiality Policy.

I give Vancouver Aboriginal Health Society permission to communicate with me via email.

If any of the information I provided above changes, I will complete a new application form.

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**Signature (sign or type full name)** **Date**