Vancouver Aboriginal Health Society

Member Application Form

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.

_____ _____

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