



Membership Application-Affiliate Chapter

Membership will expire at the end of the month in which it is applied for and will run for 12 calendar months. Please forward new and renewing membership information and dues throughout the year as applicable.

To avoid delays, please double-check information and print clearly.

Full Name of Chapter: _____

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Name & title of main contact person: _____

Telephone Number: (____) _____ Email Address: _____
(above address will receive all email sent to YOURCHAPTER@multiplebirthscanada.org)

If you have a Chapter website, what is the web address (hosted by MBC or other):

Are you interested in having MBC host your Chapter's website? Yes No

Membership Dues

Total # of Chapter Members selecting Option 1A	_____	@ \$20.00 = \$	_____
Total # of Chapter Members selecting Option 1B	_____	@ \$15.00 = \$	_____
Total # of Chapter Members selecting Option 1C	_____	@ \$10.00 = \$	_____
Total # of Sustaining Members – Option 3A	_____	@ \$60.00 = \$	_____
Total # of Sustaining Members – Option 3B	_____	@ \$50.00 = \$	_____
Number of Additional Multiple Moments copies	_____	@ \$10.00 = \$	_____

Total # of Chapter Members _____ **Grand Total: \$** _____

Note: as of July 1, 2007, a Chapter will pay MEMBERSHIP fees to a maximum of \$2,500 PER CHAPTER MEMBERSHIP YEAR. This excludes Multiple Moments subscriptions. Member details are still required for ALL Chapter members to provide them with full MBC membership benefits.

Capped: Yes No **Amount Remitted: \$** _____

Please indicate your chapter executive members and their positions on your membership list. Membership lists can be provided in Excel, Access or Word by email or in paper copy, along with a completed Form D. Form A is provided for those Chapters who do not have an official membership database. In this case, please provide copies of all Form A's and send with Form D. Provide full names (both parents), mailing addresses, phone numbers, e-mail addresses, type of multiples including zygosity (twins, triplets, etc., monozygotic, dizygotic, etc.) where possible. MBC is hoping to increase its database ability to query by demographics in the future. Please help, by providing this information.

Signature of Chapter President _____ Date _____

FOR OFFICE USE ONLY

Expiry Date _____ Amount \$ _____ Receipt # _____ Entered: Database Chapters

Multiple Births Canada will direct all mailings and referrals to the person and phone number/email address listed above. Referrals will be made to prospective members, social service and medical agencies, movie, television and casting agencies. Multiple Births Canada is not responsible of any misuse of this information.

Multiple Births Canada respects the privacy of chapter members. We protect personal information and adhere to all legislative requirements with respect to protecting privacy. We do not rent, sell or trade our mailing lists. The information provided will be used to deliver services, to keep member chapters informed and up to date on the services and activities of Multiple Births Canada.

**Send this form, along with required documents, Form A's, spreadsheets and payment to
 Multiple Births Canada, PO Box 432, Wasaga Beach, Ontario L9Z 1A4**

Telephone: (705) 429-0901 Fax: (705) 429-9809 Toll Free: (866) 228-8824
 Email: office@multiplebirthscanada.org Web site: http://www.multiplebirthscanada.org