CONFIDENTIAL ONCE COMPLETED

67, rue du Couvent, Gatineau, Qc, J9H 6A2
Telephone : **684-1234 poste 611**
E-mail address : **info@coopsa.org**
Web site : **http://coopsa.org**

Membership Application

Your clinic file number: ______________________

Identification of member

Last Name : ______________________M___F___

First Name : ______________________

Address : ______________________apt.____

City : ______________ Postal Code : _______

Tel. (home) : ______________________

Tel. (office) : ______________________

Language : English ___ French ___

A child under 18 and living with you enjoys the same privileges as you.

Last and first names	Birthday MM/DD/YYYY	Clinic file number

____________________@____________________
Your Email Address - Visit our web site: **http://coopsa.org**

I wish to subscribe five regular shares for a total sum of $50 thus becoming a member of the Aylmer health coop. Included is my payment.
I acknowledge that becoming a member of the Aylmer Health Coop does not in itself mean that I will have a family physician.

______________________ ______________
signature date

Note — Each adult in a family must complete a form and subscribe five regular shares. Cash or Interac only.

I have no family doctor.
Please put my name on the waiting list. ☐

Until the age of 18 years, I was an associate member registered under the following number: ☐

Testamentary Provision:
I bequeath my shares in the Aylmer Health Coop to the *Fondation des Soins de Santé d'Aylmer* and, upon my death, direct the Foundation to turn over the proceeds of their disposition to the Aylmer Health Coop.

______________________ ______________
signature date

Important! Personal cheques are not accepted.

Monthly payments are allowed.
Your membership application will be processed after completed payment.

Cash or Interac
At the medical clinic, 67, rue du Couvent (Aylmer sector).

Confidentiality of personal Information

The Aylmer Health Coop endeavours to keep confidential, without time limit, your personal information.