THE CENTER FOR
EPILEPSY & SEIZURE EDUCATION
IN BRITISH COLUMBIA

Member Application Form

Name: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____ Cell Phone: _____

Email: _____

How are you connected to epilepsy?

☐ Person with epilepsy ☐ Parent of a person with epilepsy ☐ Spouse of a person with epilepsy

☐ Caregiver ☐ Healthcare Professional ☐ Education Professional

☐ Other: _____

Membership entitles you to our quarterly e-newsletter and emailed announcements of upcoming events. Membership is approved at our Board of Directors meetings, and approved membership also entitles you to one vote at the Annual General Meeting of the society.

☐ Yes, please include me in your emails.

☐ No thank you, I do not wish to be included in emails.

Annual Membership Fee ☐ $2.00

Payment Options:

☐ Cash ☐ Cheque ☐ Mastercard ☐ Visa

Credit Card #: _____

Expiry Date: _____

Signature: _____ Date: _____