



Fibromyalgia Well Spring Foundation

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MEMBERSHIP APPLICATION/RENEWAL FORM

(Please print contact information)

NAME: _____

ADDRESS: _____

CITY: _____ PROV/STATE: _____ PCODE/ZIP: _____

PHONE: _____ E-MAIL: _____

Type of Membership: Personal (\$10.00) Corporate (\$50.00) Renewal (\$10.00)

Method of Payment: Cash Cheque Credit Card

Credit Card #: _____ Expiry Date: _____

Signature: _____

Would you like to help the Foundation by becoming a volunteer? Yes No

Comments (optional):

(Continue on back if more space needed)

For Office Use:

Membership #: _____

Date Received: _____

Entered in Membership list (Date): _____

Membership Application

Revised February 2012