

PERSONAL INFORMATION

Title (Mr., Mrs., Ms., Miss, Dr.): _____

First Name: _____ Last Name: _____

Address: _____

City: _____ Prov: _____ Postal: _____

Phone: _____ Email: _____

- Person Living with PD Spouse/Partner has PD Family Member/Friend Professional Health Provider
- I would like to learn more about volunteering
- I would like to receive email communications from PAA (including e-blasts, updates & information)

MEMBERSHIP

Membership is \$25 annually and is valid from January 1 to December 31

- I wish to BECOME a Member I wish to RENEW my Membership
- I would like my Parkinson Pulse Magazine mailed to me I have received my Aware in Care Kit

DONATION – Charitable #: 10809-1802-RR0001

Donations of \$20 and up will receive a tax deductible receipt

- I wish to make a DONATION in the amount of: \$ _____
- In Memory of _____ In Honor of _____

Please send notification of this gift to (name and address): _____

PAYMENT

Enclosed please find my cheque (made payable to Parkinson Association of Alberta) or cash for \$ _____

Please bill my: Visa Mastercard American Express Total \$ _____

Name on Card: _____

Card Number: _____ CVD: _____ Expiry: _____

Mail to: **PAA Calgary Head Office - 120, 6835 Railway St SE Calgary AB T2H 2V6**