CENTRE DE SANTÉ
Vallée Massawippi
Ensemble en santé | *Living Healthier Together*

Membership Form

SOLIDARITY COOPERATIVE

1082 Main Street, Ayer's Cliff, Qc J0B 1C0
: 819-838-1082
@ : information@csvm.ca
: www.csvm.ca

Personal Information

ADULTE

(complete one form per adult)

Note : Full-time student 17-21 yrs old, please use appropriate form

Last Name (at birth)				**First Name**		
Date of birth	Year	Month	Day	**RAMQ**		**Exp**
Address		**Municipality/City**			**Province**	**Postal Code**
Phone	Home		Work		Cellular	
Email (in block letters)						
Emergency (contact name and phone number)						
Family Doctor (name and phone number)			**Pharmacy** (name and address)			

- **Children from 0-16 yrs old living at the same address as the parent member do not have to subscribe for the shares;**
- **Children 0-16 years old: no annual fee to pay (of course if the parent is a member).**

Please note that the names mentioned below must be registered only on ONE form.

Child's First and Last Name	**Date of birth**	**RAMQ & Exp**
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Enrolment in the COOP

- **I hereby subscribe for 5 shares at $10 each, for a total of $50, a one-time investment, to become a member of the Massawippi Valley Health Coop.**
- **I accept to pay the annual membership fees (taxable and non-refundable).**
- **I acknowledge having read all the information on the reverse side of this form and have signed where indicated.**

Signature et Method of payment

The membership form must be accompanied by the payment

Share Purchase Investment:

$50

☐ **CREDIT CARD:** ☐ **VISA** ☐ **Mastercard :** _____

Exp. _____ **3-digit on reverse side :** _____

Print name of card holder: _____

☐ **CASH: please remit the amount of $50 to the staff of the Health Centre during the opening hours - do not mail cash.**

☐ **CHEQUE: please make cheque payable to Massawippi Valley Health Centre. (Please send it by mail with the form to the Health Centre or you may come and meet us at the Health Centre during the opening hours)**

Signed in _____ **,** _____

(municipality) **(date)**

X Member's signature _____

ADDITIONAL INFORMATION

Please read carefully the information below and sign at the bottom **ADULT**

Advantage

1. To be member at the CSVM:
   - Access to medical and professional services and nursing care such as blood tests, blood pressure checks, vaccinations, changing bandages, etc.
   - I can sign up and participate in disease prevention and health promotion programs organized by the cooperative.
   - I can take part each year in the annual General Assembly meeting for the purpose of collaborating with my leaders and fellow members. I will learn about the operation of the CSVM, ask questions and participate in the decision-making process.
   - I can take pride in knowing that I am contributing directly to the social and economic growth of my environment while showing support for my community.
2. The Coop undertakes not to disclose any personal information about its members.
3. The share and the annual membership fees are used to help finance the operations of the health centre, services provided by nurses and prevention and health promotion. Please note that the shares and fees do not constitute a prerequisite or priority to access a practicing physician at the coop health centre.
4. I would like to contribute to the life of the community and become involved in this social development:

   ◯ Yes ◯ No

   My skill are:

5. Fees may be changed at the direction of the Board of Directors

COTISATION	ANNUELLE	MENSUELLE
ADULT MEMBER	**$234 / year:** $203.52 plus GTS (5%) plus QST (9.975%)	**$19.50 / month:** $16.96 plus GTS (5%) plus QST (9.975%)

MODE DE PAIEMENT	INSTRUCTIONS ET/OU DOCUMENTS À JOINDRE avec formulaire d'adhésion
ANNUAL CREDIT CARD ☐ **$234** ☐ Utilisez la même carte que pour les parts sociales	☐ **VISA** ☐ **Mastercard :** _____ **Exp.** _____ **3-digit on revers side :** _____ **Print name of card holder :** _____
PRE-AUTHORIZED ANNUAL DEBIT ☐ **$234**	• **Bank form (PAD)** • **Void cheque**
PRE-AUTHORIZED MONTHLY DEBIT ☐ **$19,50**	• **Bank form (PAD)** • **Void cheque**
ANNUAL CHEQUE OR CASH ☐ **$234**	• **Make cheque payable to: CSVM** • **Send these documents by mail or remit them to the staff of the CSVM during the opening hours (Do not mail cash).**

☐ The FVM (Massawippi Valley Foundation) is responsible for raising funds to meet the annual deficit of the CSVM. Please check this box and initial if you consent to the CSVM sharing your email address with the FVM.
I may withdraw my consent from FVM at any time. _____

I accept to pay the annual NON-REFUNDABLE membership fees.

I acknowledge that I have read and understood all the above terms.

X _____ _____

Member's signature **(date)**

RÉSERVÉ AU PERSONNEL **Numéro du membre :** _____

☐ **Demande d'autorisation légale de signature si le formulaire est rempli pour un autre membre.**
☐ **Reçu émis**

Signature du receveur de la demande d'adhésion **Date**

Rev. 2024/04/10