

To fax or mail us: Please complete and print this form.

CMHA Membership Form

Count me in! I wish to become a member of CMHA Toronto.
 I wish to renew my membership.

Membership Fee

- Individual \$20
- Limited Income \$5
- Non Profit / Small Business \$ 50
- Corporate \$ 100

I also wish to make a donation to the work of CMHA Toronto:

Through a one-time donation of:
\$ _____ \$25, _____ \$50, _____ \$100, \$ _____

- Through the Monthly Gift Program.
My gift will be \$ _____ per month.
I understand that I can change this agreement by notification in writing to the Canadian Mental Health Association Toronto Branch.

I hereby authorize CMHA Toronto to withdraw from my:
_____ Bank Account _____ Credit Card

Please send a cheque marked Void or complete the credit card information below.

Your gift will be debited from your bank account or credit card on the 15th of each month.

Name: _____

Address: _____

City: _____

Province: _____ Postal Code _____

Telephone: _____

Email _____

Credit Card Information

__VISA __MasterCard __AMEX

Card Number _____

Expiry Date _____

Name on Card _____

Signature _____

I would like to receive information on Planned Giving

Print out and Mail/Fax to

**The Canadian Mental Health Association Toronto Branch
700 Lawrence Avenue West
Suite 480
Toronto ON M6A 3B4**

Fax: 416-789-9079

Thank you for your support.