BC Health Coalition

Canadian Doctors for Medicare
CDM MCRP
Médecins canadiens pour le régime public

"Yes, I'll support defending public health care in court"

PLEASE ACCEPT MY DONATION OF:

___$30 ____$50 ____$75 ____$100 ____$200 or ____Other

____ My cheque, payable to "BC Health Coalition-Legal Defence Fund" is enclosed.

Please bill my: ____Visa ____Mastercard

_____/_____/_____/_____ _____/_____
Card Number Expiry Date

_____ _____
Signature Date

ORGANIZATION/GROUP/INDIVIDUAL INFORMATION:

Name: _____

Contact Name (if organizational donation):_____

Position: _____ Website: _____

Address: _____
Street City

_____
Province Postal Code

Phone: _____ Email: _____

Signature_____ Date_____

___ I would like to join the BCHC e-news list.

___ I would like to receive e-mail action alerts.

___ Exchanging our mailing lists with other carefully screened non-profits helps us reach new members. However, if you don't want us to trade your name, please check this box.

PLEASE RETURN FORM AND PAYMENT INFORMATION TO:
BC Health Coalition, 302-3102 Main Street, Vancouver, B.C. V5T 3G7

Due to the advocacy nature of our work we cannot issue tax receipts.