

**OCEANSIDE STROKE RECOVERY SOCIETY
MEMBERSHIP REGISTRATION INFORMATION
FOR CALENDAR YEAR 2017**

FIRST NAME	
LAST NAME	
HOME PHONE NUMBER	
CELL PHONE NUMBER	
EMAIL ADDRESS	
ADDRESS	
TOWN	
POSTAL CODE	
NAME OF SPOUSE/PARTNER/FRIEND	
SPOUSE/PARTNER/FRIEND PHONE NUMBER	
SPOUSE/PARTNER/FRIEND EMAIL	
ARE YOU A STROKE SURVIVOR	YES _____ NO _____
ARE YOU A CARE GIVER	YES _____ NO _____
ARE YOU A VOLUNTEER	YES _____ NO _____
BIRTHDAY INFORMATION	MONTH _____ DAY _____
EMERGENCY CONTACT NAME & NUMBER	
HOW DID YOU FIND OUT ABOUT OUR GROUP?	
MEMBERSHIP FEE FOR 2017: \$45.00 PER PERSON amount paid \$ _____ by CASH ____ by CHEQUE ____ (Please include payment when returning this completed form)	

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