



APPLICATION FOR COMMERCIAL MEMBERSHIP

Company Name: _____

Contact Person: _____

Address: _____

Town/City: _____ Postal Code _____

Web Page: _____

E-mail: _____

Telephone #: _____ Fax #: _____

Description of Business - products/services:

Signature

Date

Annual Fee: **\$420.00**

Forward your completed Application Form with payment to:

BC Care Providers Association

301 - 1338 West Broadway

Vancouver, BC V6H 1H2

Fax: 604 736 4266