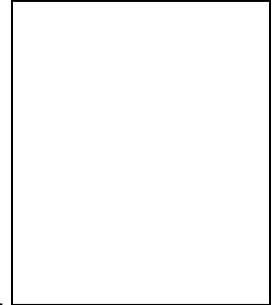




## Membership Form



First Name: ----- Last Name: -----

Address: -----

City: ----- State/Province: ----- Postal code/Zip: -----

Country: ----- Cell: ----- Email: -----

Academic Qualification: -----

Resources or Skills that you might bring to the work of IMCHF:

### Agreement:

IMCHF is committed to help pregnant mother, Newborn & Children.

I fully agree with and am willing to subscribe to the objectives of IMCHF.

I Accept    Signature -----

### FOR OFFICE USE

Approval Date: ----- Membership Number: -----

Board of Director: ----- Signature: -----

Website: [www.imCHF.org](http://www.imCHF.org) Email: [info@imCHF.org](mailto:info@imCHF.org)

Phone: 1- 4506280328 Address: 801 Normand, Laval, QC, h7p3z2, Canada. Payment Information: Bank Name: Canada Trust, Branch Address: Ste Rose, 727 Cure Labelle Blvd, Ste Rose, PQ, CAN, h715r7. International Maternal and Child Health Foundation.

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