



**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: **\$400.00**

Forward your Application Form with payment to: BC Care Providers Association Fax: 604 736 4266  
301 - 1338 West Broadway Email: [info@bccare.ca](mailto:info@bccare.ca)  
Vancouver, BC V6H 1H2

Payment Methods:

**CHEQUE:** Made payable to **BC Care Providers Association**

**CREDIT CARE:**  Visa  Mastercard  Amex

**CARD #:** \_\_\_\_\_ **EXP** \_\_\_\_ / \_\_\_\_

**Name on Card:** \_\_\_\_\_

**Authorization Signature:** \_\_\_\_\_