AIDS Coalition of Nova Scotia 20 YEARS

5516 Spring Garden Road, Suite 200 Halifax Nova Scotia B3J 1G6
902•425•4882 • 902•429•7922 • fax 902•422•6200 • acns@acns.ns.ca

Membership Form

Name_____

Address _____ Apt No. _____

City _____ Province _____ Postal Code _____

Phone (day) _____ Phone (evening) _____

Email _____
You can unsubscribe at any time.

Preferred Contact Methods (select ALL that apply)

□ Phone □ Email □ Mail

Do you wish to join the ACNS LISTSERV to receive occasional updates?

□ Yes please! □ No thank you.

Declaration

I, _____ verify that I am over 19 years of age and
(print name)

that I endorse the vision and mission of the AIDS Coalition of Nova Scotia.

Signature

By signing below, I confirm that the above information I have provided is true and I declare that I am committed to the Mission of ACNS, its governing principles and values. I understand that any information I provide will be kept strictly confidential.

_____ _____ _____
Name (please print) Signature Date