AIDS Coalition of Nova Scotia

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Membership Form

Name _____

Pronouns (*He, She, They, Zie, etc.*)_____ Email _____
You can unsubscribe at any time.

Address _____ Apt No. _____

City _____ Province _____ Postal Code _____

Phone (day) _____ Phone (evening) _____

Preferred Contact Methods (select ALL that apply)

☐ Email ☐ Mail ☐ Phone

Do you wish to join the ACNS LISTSERV to receive occasional updates?
We send approximately 15 – 18 communications per year.

☐ Yes please! ☐ No thank you.

Declaration

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

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