



**COMMUNITY FIRST HEALTH CO-OP**  
*Building Healthy Communities*

Suite 204 - 518 Lake Street  
 Nelson, B.C. V1L 4C6  
 E-mail: [cfhcoop@shaw.ca](mailto:cfhcoop@shaw.ca)  
 Website: [www.healthco-op.ca](http://www.healthco-op.ca)

**APPLICATION FOR MEMBERSHIP AND SHARE SUBSCRIPTION AGREEMENT**

Incorporated under the Co-operative Association Act (SBC 1999)  
 Incorporation No. CP1935 on February 27, 2003

I / WE \_\_\_\_\_, hereinafter referred to as  
*please print name of applicant(s); if joint – the first name to appear shall be the voting member*

the “applicant”, hereby apply to the **COMMUNITY FIRST HEALTH CO-OP**, (referred to as “the Co-op” for the purpose of this application), for membership in the Co-op and subscribe for the purchase of \_\_\_\_\_ shares in the authorized capital stock of the Co-op in accordance with the terms and conditions of the Co-op’s *Memorandum and Rules of Incorporation*.

The applicant tenders the sum of \$ \_\_\_\_\_ on account for the payment of share(s) subscribed for.

The applicant agrees to be bound by the *Memorandum and Rules of Incorporation* of the Co-op, if the Co-op accepts the applicant as a member. (*Copies of the Memorandum and the Rules of Incorporation are available upon request or visit our website*).

The applicant acknowledges receipt of the *Memorandum of Understanding* form, \_\_\_\_\_  
*Please initial*

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_ AD,

In or about the City or Place of \_\_\_\_\_, in the Province of British Columbia.

\_\_\_\_\_  
*(Applicant's signature or authorized signature if corporate)*

\_\_\_\_\_  
*(Title if corporate)*

**MEMBERSHIP TYPE**

Regular (1) share \$ 10.00  
*(individual or joint)*

Corporate (10) shares \$ 100.00

Enhanced Membership \$10.00 per share  
*(purchase outright or add to basic membership)*

Copper (5) shares

Bronze (10) shares

Silver (20) shares

Gold (50) shares

Platinum (100) shares

Check here if you are an existing shareholder

**For Corporate Members**

We hereby appoint the following \_\_\_\_\_  
*(please print name)*

and whose signature appears below as our Representative, until further written notice to the Co-op

\_\_\_\_\_  
*Authorized Corporate Signature*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Corporate Representative's signature (if not the same as above)*

Please indicate Method of Payment

Cash

Cheque (*Payable to Community First Health Co-op*)

**Contact Information:** (*Required for all applicants*)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Email:** \_\_\_\_\_