Centre for Health Care Ethics
t: (807) 343-8126
e: chce@lakeheadu.ca
http://chce.lakeheadu.ca

"CHCE" INSTITUTIONAL MEMBERSHIP ENROLLMENT

Name of Institution: _____

Mailing Address: _____

_____

_____

Street Address: _____

Administrator or
Chief Executive Officer: _____

Contact Person regarding this membership, if different from Administrator or CEO:

_____
Name

_____
Position

For further communication, the Contact Person may be reached at the above address or at:

Telephone: _____ Fax: _____ E-mail _____

I wish to enroll _____ as an Institutional Member of the Centre for Health Care Ethics, Lakehead University. Our Institutional Membership Fee for the current year will be $ _____ plus HST. A cheque for this amount will be issued to **"Lakehead University Centre for Health Care Ethics".**

☐ The cheque will be included with this enrollment form. ☐ The cheque will be mailed separately.

Date: _____ Signature: _____

Mailing Address: Lakehead University
Centre for Health Care Ethics
955 Oliver Road
Thunder Bay, ON P7B 5E1

Website: http://chce.lakeheadu.ca