



Canadian Hemophilia Society - BC Chapter

FUNDING APPLICATION

(Please print clearly and complete the entire form)

APPLICANT'S NAME: _____

NAME OF CHILD: _____
(if applying for a minor)

MAILING ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

DATE: _____

Please indicate which funding you are applying for:

☐ **MEDIC ALERT ID** ☐ **CAMP I-VY** ☐ **PCGF** Item: _____

☐ **ACTIVITY FUND** ☐ **CAMP ZAJAC** ☐ **TRAVEL TO CLINIC** Date: _____

To be eligible for any of the funding provided by the BC Chapter, applicants must be a current member of the BC Hemophilia Society and must be diagnosed with an inherited bleeding disorder. Please attach receipts and supporting documents (if applicable).

I _____ give consent to the BC Chapter representative to verify that I am

or that my child _____ is registered with the BC Bleeding Disorder Clinic.

Signature

Date

Mail to:

CHS - B.C. Chapter
P.O. Box 21161 Maple Ridge Square, RPO
Maple Ridge, B.C. V2X 1P7

OFFICE USE ONLY

Membership current	
Registered @ clinic	
Application approved	
Receipt(s) received	
Receipt(s) approved	
Cheque issued	