



Medicine Hat & District Child Care Association

New Membership Renewal of Membership

ASSOCIATE MEMBERSHIP

For any person, group or agency supportive of the MHDCCA's goals

Date: _____

Name: _____

Address (including postal code): _____

Telephone #: _____ Fax #: _____

Email Address: _____

Member Information (please select one):

Child Care Professional Qualification level: _____

Support Staff for a child care facility

Student Program of study: _____

Agency/Organization Please specify: _____

Other Please specify: _____

Membership Commitment

- *Members are required to read and sign the MHDCCA By-laws.*
- *Members are required to send a representative to attend a minimum of 3 meetings/year.*
- *Associate members are eligible to vote.*
- *Associate members may hold a position on the MHDCCA executive.*

I have read and understand the above statements: _____

Membership Fees:

- *Membership fees are \$100 for associate members.*
- *Separate membership applications must be submitted for each member.*
- *Membership is valid until March 31.*
- *Membership fees are non-refundable.*

Please mail membership form and cheque to: **Medicine Hat & District Child Care Association**
640 Third Street SE
Medicine Hat, AB
T1A 0H5

For Office Use Only: _____ Fee Received

Building a Strong Foundation in Child Care Since 1989

www.mhdcca.com