

**VOICES IN ADOPTION EVENT
REGISTRATION FORM
2008**

TITLE <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS. <input type="checkbox"/> MISS <input type="checkbox"/> DR.		
FIRST NAME		LAST NAME
AGENCY/ORGANIZATION (IF APPLICABLE)		
POSITION		
MAILING ADDRESS		
CITY	PROVINCE	POSTAL CODE
PHONE ()	EMAIL	
PAYMENT		
<input type="checkbox"/> \$30 (GENERAL) <input type="checkbox"/> \$25 (STUDENT) CHARITABLE CONTRIBUTION <input type="checkbox"/> \$15 <input type="checkbox"/> \$20 <input type="checkbox"/> \$25 <input type="checkbox"/> \$30 <input type="checkbox"/> OTHER AMOUNT \$ _____ TOTAL \$ _____ <i>INCOME TAX RECEIPT</i> <input type="checkbox"/> YES <input type="checkbox"/> NO		
PAYMENT METHOD <input type="checkbox"/> CHEQUE <input type="checkbox"/> MONEY ORDER <input type="checkbox"/> VISA <input type="checkbox"/> MASTER CARD <input type="checkbox"/> AMEX		
NAME OF CARD HOLDER		
CREDIT CARD NUMBER		EXPIRY DATE (MM/YY)
SIGNATURE		

I AM (PLEASE CHECK ANY THAT APPLY):

- | | |
|---|---|
| <input type="checkbox"/> Adoptive parent
<input type="checkbox"/> Birth parent
<input type="checkbox"/> Foster parent
<input type="checkbox"/> Social worker
<input type="checkbox"/> Researcher/academic | <input type="checkbox"/> Prospective adoptive parent
<input type="checkbox"/> Adoptee
<input type="checkbox"/> Prospective foster parent
<input type="checkbox"/> Health professional
<input type="checkbox"/> Other: |
|---|---|

Please return completed registration forms to:

Adoption Council of Canada
 211 Bronson Avenue
 Ottawa ON K1R 6H5
 Email: sarah@adoption.ca
 Fax: 819-682-4055

Questions? 1-888-54-ADOPT