**NAME of COUNTRY:**

In your language:

In English:

**NAME of Association / Organization:**

In your language:

In English:

**Association / Organization Address:**

Street:

City:

State/Province/Canton:

Zip:

Country:

Telephone: Country Code: Area Code: Number:

Fax:

Email:

Website:

**Chief Elected Officer *(Name & Title, Ex: President)***

**Chief Staff Officer *(Name & Title, Ex: Executive Director)***

Name of Association / Organization (enter below) Current Number of Members:\_\_\_\_\_\_\_

formally wishes to join the World Naturopathic Federation (WNF) as an Associate Member &

1. Please check the following and confirms that your organization:

\_\_\_\_\_\_ has read and agrees with the Mission Statement of the WNF

\_\_\_\_\_ is a legally constituted non-profit naturopathic association or organization that represents the naturopathic profession.

1. Encloses:

* A cheque/check in payment of membership dues. The annual fee for Associate Membership is USD$100 if the number of naturopaths is 50 or less) or alternatively USD$2 per member to a maximum of USD$2500

Please make cheque/check out to *World Naturopathic Federation*

Mail cheque/check to World Naturopathic Federation

20 Holly Street, Ste 200

Toronto, Ontario

M4S 3B1

On behalf of the Association / Organization, I hereby acknowledge that we meet the membership criteria for an Associate Member of the World Naturopathic Federation.

**Dated at**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_20\_\_

**Signature**:

**Signed for and on behalf of the Association / Organization by**:

Please **print** name and title