The World Naturopathic Federation welcomes individuals, naturopaths, naturopathic doctors and naturopathic clinics that support the Mission of the WNF.

**NAME of COUNTRY:**

(in English)

**NAME of Individual / Clinic:**

(in English)

**Contact Information:**

Telephone: Country Code: Area Code: Number:

Email: Website (if a clinic):

□ Please verify that you have read the [WNF Mission Statement](https://worldnaturopathicfederation.org/mission-of-the-wnf/) and that you are in agreement.

□ Please verify that you have read the criteria and benefits for WNF Supporters and that you are in agreement.

□ Please indicate that you approve your name being listed on the WNF website

If yes, please specify how you would like the listing to appear:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Amount** (please select)**:**

\_\_\_\_\_\_ USD$1,000 \_\_\_\_\_\_ USD$500

\_\_\_\_\_\_ USD$250 \_\_\_\_\_\_ USD$100

\_\_\_\_\_\_ USD$50 \_\_\_\_\_\_ USD$25

\_\_\_\_\_\_ Other amount

*Upon receipt of your application we will send you an invoice.*

**Payment Method:**

Please check the method of payment you wish to use:

\_\_\_\_\_ PayPal: *An email request will be sent to you upon receipt of this application*.

\_\_\_\_\_ Cheque:

Please make cheque payable to *World Naturopathic Federation*

Mail cheque to:  
*World Naturopathic Federation*

20 Holly Street, Ste 200

Toronto, Ontario, Canada M4S 3B1

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

**Signature**: