SCLERODERMA ATLANTIC
SCLÉRODERMIE ATLANTIQUE

The David Shea Memorial Support Fund
Application Form

Date: _____

Full Name: _____

Email: _____

Phone Number: _____

I confirm that I am living with scleroderma (please use check mark) _____

Mailing Address Line 1: _____

Mailing Address Line 2: _____

Postal Code: _____

Province: _____

I would like to receive occasional emails from Scleroderma Atlantic with helpful information, organization updates, and more. _____ Yes _____No

Please list the type of expense being submitted for reiml ment and include copies of the receipts with your application. If you need more space, p use the back of this page.

_____

_____

_____

_____

If you are mailing your application, please send it to:

PO Box 31102

6155 North Street

Halifax, NS B3K 4P0