

# Lymphatic Health Canadian Collective (LHCC) Public Voting Member



LHCC #:

Date :

## LHCC Relationship



Patient



Public Information

First  
Name

Last  
Name

Address

City/Province

Post Code:

Phone No

E-Mail

## Advisor's Bio

Business Organization Name :

Website / E-Mail :

Position Business :

Phone Number :

Full Address :

May we ask you for a short profile bio ?

☐

Yes

☐

No

Signature Of Author