



Application for Membership

Full Name	Mr / Mrs / Ms / Miss / Dr / Prof		
Address			
		Postcode	
Home Tel		Work Tel	
Mobile Tel		Email	

Applicant's relationship to a person receiving a Cerebral Palsy Alliance service:

Self Parent Guardian Other relative Other

Details of person receiving a Cerebral Palsy Alliance Service

Full Name	
Date of Birth	

Tax Invoice – ABN 45 000 062 288

Type of Membership (Please check the appropriate box)

Member with a Disability Support Member Invited Member
(Parent, Primary Carer, Guardian)

Membership Fee (Please check the appropriate box)

\$30 for 1 year \$80 for 3 years \$100 for 4 years

Voluntary Contribution (Donations will be acknowledged by an official receipt)

\$10 \$20 \$50 \$100 Other amount \$

Payment Options

I/ We hereby apply to be admitted to Cerebral Palsy Alliance and if so admitted agree to be bound by the Constitution of Cerebral Palsy Alliance.

Yes

I/We enclose cheque/money order for \$

OR please charge my Mastercard Visa American Express

Number

Amount \$ Expiry Date [Click here to enter a date.](#)

Signature	
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Office use only

Please post this form, together with payment, to:

Company Secretary
P.O. Box 171 FORESTVILLE NSW 2087

A/C: 10 701 000 4049
Membership
10 701 000 4022 Donations