# Application for Renewal of Membership

Cerebral Palsy ALLIANCE

**Please Print**

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

I would prefer to receive notification of newsletters/ events via ☐ electronically ☐ post

I would prefer to receive a copy of the Annual Report via ☐ electronically ☐ post

---

Tax Invoice – ABN 45 000 062 288

## Type of Membership (Please tick the appropriate box)

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

## Membership Fee (Please tick the appropriate box)

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

## Voluntary Contribution

(Donations of $2.00 or more are tax deductible and will be acknowledged by an official receipt)

☐ $10 ☐ $20 ☐ $50 ☐ $100 ☐ more than $100.00 - $

## 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.

Signature/s Date / /

I/We enclose cheque/money order payable to Cerebral Palsy Alliance for

OR please charge my ☐ Mastercard ☐ Bankcard ☐ Visa ☐ American Express

Name on card

Card number

Amount Expiry date Signature

**Please post this form, together with payment, to:**

Company Secretary
P.O. Box 171 FORESTVILLE NSW 2087

---

**Office use only**

A/C: 10 701 401 000 4049 Membership Donations
FINANCE 1

10 635 401 000 4022 Donations
TQ DONMEM