Application for Membership

Cerebral Palsy ALLIANCE

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 (Parent, Primary Carer, Guardian)** ☐ **Invited Member** ☐

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	

Office use only

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

Please post this form, together with payment, to:

Company Secretary
P.O. Box 171 FORESTVILLE NSW 2087