Application for Membership

Cerebral Palsy ALLIANCE

Member Details

Full Name	Mr / Mrs / Ms / Miss / Dr / Prof		
Address			
		Postcode	
Contact Tel		**Email**	

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

Self ☐ **Parent** ☐ **Guardian** ☐ **Other relative** ☐

Details of person receiving a Cerebral Palsy Alliance Service

Full Name	
Year of Birth	

Preferences (Please check the appropriate box)

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

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

Type of Membership (Please check the appropriate box)

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

Agreement

I apply to be admitted as a Member of Cerebral Palsy Alliance (ABN 45 000 062 288) and if so admitted agree to be bound by the Constitution of Cerebral Palsy Alliance.

Signature		**Date**	

Voluntary Contribution

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

$10 ☐ **$20** ☐ **$50** ☐ **$100** ☐ **Other amount** ☐ **$**

Payment Options

Please charge my **Mastercard** ☐ **Visa** ☐ **American Express** ☐

Number

Amount **$** **Expiry Date:**

Signature	

Please post this form to:
Company Secretary
P.O. Box 171 FORESTVILLE NSW 2087

Office use only

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

Your personal information is collected and used in accordance with Cerebral Palsy Alliance's Collection Notice – Members.