



Application for Membership

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

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	
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Please post this form to:

Company Secretary

P.O. Box 171 FORESTVILLE NSW 2087