

APPLICATION FOR NEW MEMBERSHIP

First Name: _____

Last Name: _____

Date of Birth: _____

Ethnicity: _____

Occupation: _____

Email: _____

Phone: _____

Mobile: _____

Postal Address: _____

Postcode: _____

Please tick the box that best matches your circumstances:

I have CP A member of my family has CP I/We do not have CP

Person with CP (If different from above):

Name: _____

Date of Birth: _____

Type of Membership

Individual with CP \$10 per year \$

Family member (family of a member with CP) \$15 per year \$

Associate member \$10 per year \$

Join up to 4 years in advance
_____ years x fee subtotal \$

(Optional) A donation of \$

TOTAL \$

Payment options:

Membership fees can be paid by cheque, cash or direct credit to the Society's account 12-3011-0809757-00. Please use your first and last name as a reference. Your new membership will be confirmed following the next bi-monthly Board meeting.

Please send this form to the Society for processing regardless of your mode of payment. You can post it to:

CP Society
DX Box CP 31005
Newmarket
Auckland

Or scan and email it to cpsociety@cpsociety.org.nz

You can also complete a Membership Application online at cpsociety.org.nz

If accepted for membership I/we undertake to be bound by the Constitution of the Cerebral Palsy Society of New Zealand Inc.

Signed: _____ Date: _____

0800 503 603
cpsociety@cpsociety.org.nz
DX Box CP 31005,
Newmarket, Auckland
www.cerebralpalsy.org.nz

