

Application for Renewal of Membership



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 Invited Member
(Parent, Primary Carer, Guardian)

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 Memorandum and Articles of Association of the Company.

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 6427 FRENCHS FOREST NSW 2086

Office use only

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

10 635 401 000 4022 Donations
TQ DONMEM