

MEMBERSHIP FORM



NAME:

AGE: DATE OF BIRTH:

ADDRESS:

..... POST CODE:

TELEPHONE (HOME):

MOBILE:

E-MAIL:

IN CASES OF EMERGENCY, WHOM SHOULD WE CONTACT?

NAME:

RELATIONSHIP TO YOU:

MOBILE LAND LINE

DO YOU SUFFER FROM ANY ILLNESSES WHICH YOU HAVEN'T PREVIOUSLY INFORMED US ABOUT, BUT WE SHOULD KNOW ABOUT, EG ASTHMA ETC? IF YES, PLEASE STATE BELOW:

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.....

Signed: (Date):

