MEMBERSHIP APPLICATION FORM

Name (Prof / Dr / Mr / Mrs / Miss / Ms): _____

Name of Organisation (for Corporate Membership): _____

NRIC / FIN / UEN No: _____ Date of Birth (DD/MM/YY): _____/_____/_____

Address: _____

_____ Postal Code: _____

Tel: _____ (H) _____ (M) _____ (O) _____ (F)

Email Address: _____ Gender: F / M

Occupation: _____

Language(s) Spoken: _____

I am a:

- ☐ Stroke survivor
- ☐ Caregiver
- ☐ Healthcare professional (Name of organisation: _____)
- ☐ Others (Please specify: _____)

I would like to apply for:

- ☐ Ordinary membership ($10 / year)
- ☐ Life membership ($80)
- ☐ Associate membership ($5 / year)
- ☐ Corporate membership ($500)

By signing the application form, I indicate my agreement to and acknowledgement of the following:

- *Persons below 18 years of age shall not be accepted as members without the written consent of their parents or guardians.*
- *The personal information which I have provided will be used solely for the following purposes: (a) Processing of membership application (b) Communication and publicity of SNSA's programmes/initiatives/collaterals (c) Assessing of needs for service improvement (d) Purposes related to the services SNSA is providing and/or on matters relating to my ongoing membership with SNSA. The information provided will not be disclosed to a third party without my consent. This membership may be terminated upon my written request.*

_____ _____

(Signature) (Date)