AUSTRALIAN KABUKI SYNDROME ASSOCIATION INC.

ABN 63 186 247 664

PO Box 507 Kensington Park SA 5068

www.kabukisyndromeassoc.com.au

CONSUMER MEMBERSHIP

(1st January to the 31st December)

OPEN TO ALL PERSONS WITH KABUKI SYNDROME

APPLICATION FOR MEMBERSHIP

NAME: ……..……..

DATE OF BIRTH: ……..…….. GENDER: M F

If **over** 18 years of age, do you have dual membership (i.e. have Full Membership) YES NO

PARENT'S / GUARDIAN'S NAME: ……

ADDRESS: ……

……POST CODE……..…….

PHONE NOS.: (H)…… (M) …… (W) ……

EMAIL……...Fax……..

CONSENT: to use your photographs (only) to enhance the awareness of Kabuki syndrome.

YES NO Signature ……**DATE / / 200**

Please circle if you also consent to the use of: First Name: Age: State/Territor:

Parents/Guardian/Member - please indicate any information that may help Management with future planning.

COMMENTS / SPECIAL INTERESTS. etc.

OFFICE USE ONLY: Date received: / / 200 Membership Number: K.00……