

## MEMBERSHIP APPLICATION FORM

I wish to enrol as a member of the Post Polio Support Society of New Zealand Incorporated. The annual subscription is due each July 1st.

SURNAME: Mr Mrs Miss Ms Dr

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FIRST OR PREFERRED NAME:

\_\_\_\_\_

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POSTAL ADDRESS:

\_\_\_\_\_

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Postal Code: \_\_\_\_\_

PHONE NUMBER: (0 \_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

YEAR IN WHICH YOU CONTRACTED POLIO: \_\_\_\_\_

LOCATION: \_\_\_\_\_

Signature: \_\_\_\_\_

Please post this application form and membership fee to:  
Post Polio Support Society of NZ Inc., P.O. Box 249, Oamaru.