



## Application for Family Membership (\$35 per annum)

Spina Bifida Foundation of Victoria Incorporated (SBFV)

First name _____ Surname _____
Street _____
Suburb _____ State _____ Post code _____
I wish to apply for family membership of Spina Bifida Foundation of Victoria Incorporated.
Signature of applicant _____ Date _____

### Primary Member Details (additional family member details next page):

Title <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Other (please specify) _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F
First name _____ Surname _____
Do you have Spina bifida? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of birth _____

Postal address <input type="checkbox"/> (please tick box if same as above or write below)
Street _____
Suburb _____ State _____ Post code _____

Telephone ( ) _____ Mobile _____
e-mail _____
Would you prefer to receive information via <input type="checkbox"/> e-mail <input type="checkbox"/> Post

If you do **NOT** wish to have your name recorded on the FINE register and receive bi-annual mail outs about folate and related health issues, please tick this box.

**Additional Member Details:**

Please specify relationship to primary member \_\_\_\_\_

Title  Mr  Mrs  Ms  Other (please specify) \_\_\_\_\_ Sex  M  F

First name \_\_\_\_\_ Surname \_\_\_\_\_

Do you have Spina bifida?  Yes  No Date of birth \_\_\_\_\_

Please specify relationship to primary member \_\_\_\_\_

Title  Mr  Mrs  Ms  Other (please specify) \_\_\_\_\_ Sex  M  F

First name \_\_\_\_\_ Surname \_\_\_\_\_

Do you have Spina bifida?  Yes  No Date of birth \_\_\_\_\_

Please specify relationship to primary member \_\_\_\_\_

Title  Mr  Mrs  Ms  Other (please specify) \_\_\_\_\_ Sex  M  F

First name \_\_\_\_\_ Surname \_\_\_\_\_

Do you have Spina bifida?  Yes  No Date of birth \_\_\_\_\_

If further immediate family members need to be listed please attach additional sheets.

**Payment Details:**

Please charge \$ \_\_\_\_\_ to my  Bank Card  Master Card  Visa

Name on card \_\_\_\_\_

Card number

Expiry date   /

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please accept my enclosed cheque for \$ \_\_\_\_\_

**Please return the completed form to:**  
**Spina Bifida Foundation of Victoria**  
**4<sup>th</sup> Floor Ross House**  
**247-251 Flinders Lane**  
**Melbourne VIC 3000**

**Credit card payments can also be accepted by either:**  
**Ph (03) 9663 0075**  
**or**  
**Fax (03) 9639 0081**

SBFV is committed to protecting the privacy of all persons, and confidentiality of personal information obtained whilst undertaking its activities. The information provided on this form may be used for research or presentation purposes; however names, personal details or identity will not be displayed or disclosed without express consent from the individual.