



MEMBERSHIP APPLICATION FORM

PLEASE COMPLETE THE FOLLOWING USING BLOCK LETTERS

Name Mr/Mrs/Ms:

D.O.B: ID No:

Permanent Address:

.....

Present Address:

.....

Nationality:

Telephone Numbers:

Home: Office:

Mobile:

E-mail:

The association invites patients with congenital heart condition and their parents/guardians as special members.

Special members are required to provide additional information to enable us to provide necessary support.

Please indicate if you are a special member: Yes: No:

Relation with patient:.....

All special members are required to fill an additional form available from this association.

Membership understanding:

*All members should abide by the relevant laws governing this association and any other resolutions passed by the relevant ministries

*All members are encouraged to actively participate in all activities of the association.

*Do you have any particular area of interest or specialties that could be of benefit to the activities of the association please specify.

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* Upon approval of your membership by the executive committee you will receive your membership number on a card including other information.

The membership card is a property of this association. In the event a member leaves the association, the card should be returned for cancellation.

Ihave read and fully understood the above mentioned terms and agree to abide by them.

Sign: Date:

Official use:

Membership no: 0807.....

Authorized by:

Card Issue date:

Membership Type:

I have received my Membership card from Tiny Hearts of Maldives.

Date:

Card received by:

Sign: