



CEREBRAL PALSY SUPPORT NETWORK

strength through connection

MEMBERSHIP REGISTRATION FORM

MEMBERSHIP FEES

*People with Cerebral Palsy and their immediate family: **FREE**

Interested individuals (this includes sole practitioners i.e. allied health workers and extended family members): **\$20**

Organisations (Service providers etc.): **\$50**

MEMBERSHIP IS DUE 1st JANUARY EVERY YEAR

Please fill out the membership form completely and tick relevant boxes. All information on this form is confidential.

ARE YOU:

- **A Parent or Carer of a child with CP? Please complete all sections except question 2.**
- **An Adult with CP? Please complete all sections except question 2.**
- **An Organisation, Agency or Interested Individual? Please begin at question 2.**

This is a: New Membership Membership Renewal

INDIVIDUALS & FAMILIES

1: First Name: _____ Surname: _____

I am the: Parent Carer Individual with CP

Residential Address: _____

Suburb: _____ Postcode _____

Postal Address: (if same as above tick here) _____

Phone: () _____ Mobile: _____

Email: _____ Fax: () _____

Local Council: _____ Region: _____

AGENCIES, ORGANISATIONS & INTERESTED INDIVIDUALS

2: Agency/Organisation Business Name: _____

Name and Position Held: _____

Service Provided: _____

Address: _____

(cont. P2)

2: (Agencies, Organisations & Interested Individuals cont.)

Suburb: _____ Postcode _____

Postal Address: _____

Phone: () _____ Mobile: _____

Email: _____ Fax: () _____

Local Council: _____ Region: _____

DETAILS OF THE INDIVIDUAL WITH CP

3: First Name: _____ Surname: _____

4: D.O.B: ____/____/____ Sex: Male Female

5: Diagnosis: (all information will be treated as confidential)

- Spastic Quadriplegia Spastic/Hemiplegia Spastic/Diplegia Ataxia Athetoid
- Unconfirmed

Other symptomatic areas:

- Vision Speech Feeding Hearing Intellectual Epilepsy (diagnosis):

Details: _____

Other information: _____

6: School/Centre/Program/Therapies currently being accessed: _____

7: How can the CPSN best assist you? _____

8: Do you want information about the Respite Brokerage Program? Yes No

Signature: _____

Please sign completed form

Date: ____/____/____

- **Membership Fees are payable to: "Cerebral Palsy Support Network" or "CPSN" by Cheque or Money Order. Attach payment with this completed Membership Form if sending by post.**
- **Cash payments (in person only) to our office: 86 Herbert Street, Northcote, Vic 3046. Please do not send cash by post.**
 - **Receipts are not issued unless specifically requested. All new Members receive a Membership Pack.**

**Any queries, please phone the CPSN office on
TOLL FREE: 1300 CPSN 00 (277 600)**

Please return this completed form by:

Fax: (03) 9445 7489

Mail: 86 Herbert Street, Northcote VIC 3070 Australia