# MEMBERSHIP FORM

**2**

###### Pictures

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father’s / Husband’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**D.O.B: \_\_\_\_\_\_\_\_ Blood Group:** \_\_\_\_\_\_\_\_\_ **Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### Contact: Res.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Off. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **N.I.C. No.:** |  |  |  | - |  |  | **-** |  |  |  |  |  |  |

### Please tick the activity in which you would like to participate the most:

Funds Collection Working with children suffering from Thalassaemia

Organizing Functions Blood Donation

**All the Above Activities Annual Membership (Rs. 1000)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE**

#### FOR OFFICE USE ONLY

### Membership No.: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Receipt No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Approving Authority**