

ALOPECIA AREATA SUPPORT ASSOCIATION (VIC) INC.

MEMBERSHIP REGISTRATION

Membership for Adult/Child with the Association for the financial year.....

Form of Alopecia of: Areata Totalis Universalis Other

Child Details Only (Please fill in)

Child sufferer's name..... M F

Parent of sufferer Supporter

Surname: Mr/Mrs/Ms/Miss.....

First Name:.....

Address:.....

..... Post Code:.....

Tel. No:..... Mobile:.....

Email:.....

Date of Birth (of sufferer):...../...../.....

Year Alopecia appeared:.....(approx)

Occupation:.....or/Pensioner No:.....

MEMBERSHIP CATEGORY:

Full Member: \$25.00 per year (July/June)
Associate Member: \$25.00 per year (Supporter)
Student/Pensioners/Children: \$15.00 per year (Minimum donation suggested)

Money order/cheque enclosed made payable to Alopecia Areata Support Association (VIC) Inc.
\$...... (No cash through the mail please)

Signature:.....Date:.....

Please mail to: AASA (VIC) Inc.
Marked Attention of:
Membership Registration, Treasurer
PO BOX 89
Camberwell VIC 3124

Office Use Only
Date Received:...../...../.....
Treasurer:
Receipt No:
Date: