

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: