



Associate Membership Application Form

Your Details:

Mr/Mrs/Miss/Dr/Professor/Other _____

Forenames: _____

Surname: _____

Date of Birth: _____

Tel No (Home): _____

Tel No (Work): _____

Mobile: _____

E-Mail: _____

Nominating Member Details:

Name: _____

Membership No: _____

Home Address of Associate Member:

Postcode: _____

Who is the nominating member employed by? *(Please tick as appropriate)*

Addenbrookes:

Clinical School/Cambridge University

Medical Research Council:

Mental Health Trust:

SmithKline Beecham:

National Blood Service:

Cambridgeshire PCT:

Cancer Research UK:

Retired:

Other: _____

HEALTH DECLARATION

All members (exc Social) need to participate in a Club Induction. Members can use the facilities (exc weights room) between joining and the time of their club induction. However, they must indicate in the space below that they are fit and well to use the club facilities *(please tick)*

YES

NO

Signed: _____

Date: _____

Office Use Only:

MEMBERSHIP TYPE: _____

Payment

Date of Sale: _____

Monthly/Annual Membership Fee: _____

Admin Fee: **£15.00**

Pro-Rata Payment Received: _____

Membership No: _____

Direct Debit: If member is paying monthly, then they have option of Direct Debit. Please note that if they join after 15th of each month, then they pay pro-rata for the remainder of that month, plus the full amount for the following month.

DIRECT DEBIT RECEIVED FROM MEMBER: YES/NO
(Delete as appropriate & attach mandate to form)

TOTAL PAID: _____

Proof: _____

Card Issued: YES/NO

Staff Initials: _____