

Membership Application

Please send completed forms to:
cerebral palsy plus
Vassall Centre, Gill Ave,
Fishponds
Bristol
BS16 2QQ



I/We wish to become a member(s) of cerebral palsy plus:

Name:
Address:

Postcode:
Tel No:
email:

Please tick (✓) the relevant category:

Person with cerebral palsy

Parent/Family

Name of your child:
Date of Birth:

Health professional

Other

I/ We have no objection to cerebral palsy plus keeping my details on file.

Signature:

Membership No....
(office use only)