HOPE FOR SICKLE CELL FOUNDATION (UG)

PARTNERSHIP FORM

Name: (Mr. /Mrs.) ----------

(*Use a tick*) Male: ◯ Female: ◯

CONTACT INFORMATION

Personal Tel: ---------- Home Telephone No: ----------

Emergence Mobile No: (*compulsory*) ---------- Postal Address: (*if any*) ----------

Email Address 1. : (*compulsory*) ----------

Email Address 2. ----------

RESIDENTIAL INFORMATION

Current Residential Address: ----------

TYPE OF PARTNERSHIP

Individual: ◯ Amount Paid / Item: ----------

Company: ◯ Amount Paid / Item: ----------

AMOUNT PAID FOR PARTNERSHIP

Monthly: ----------

Quarterly: ----------

Yearly: ----------

"Allowing everyone to dream"

AGREEMENT AND SIGNATURE

I Confirm and Understand that:

a) I am aged 18 or over

b) All information supplied is true.

c) If any of the supplied information is false or misleading, my partnership can be terminated.

d) By signing this document, I agree to abide by the conditions of partnership as laid out in the Hope for Sickle Cell Foundation (UG) constitution.

SIGNATURE:	
DATE:	

THANK YOU FOR COMPLETING THIS APPLICATION FORM AND YOUR INTEREST IN BECOMING A PARTNER OF HOPE FOR SICKLE CELL FOUNDATION (UG)

OFFICIAL USE ONLY

Received by ---------- Date:----------

SIGNATURE : ---------- STAMP: ----------