

Membership Form

GIVEN NAME	
FAMILY NAME	
ADDRESS	
TELEPHONE	
GSM	
FAX	
E-MAIL	
DATE AND PLACE OF BIRTH	
ACHIEVED LEVEL OF EDUCATION (W/O SCHOOL, ELEM., HIGH, TECH. SCHOOL, UNIVERSITY)	
PROFESSION AND OCCUPATION	
WORKING STATUS (EMPLOYED - IF YES, WHERE?, UNEMPLOYED, RETIRED)	
MATRIMONIAL STATUS	
I HAVE CHILDREN	
DIAGNOSIS (PARAPLEGIA, PARAPARESIS, QUADRIPLÉGIA, QUADRIPARESIS)	
DATE OF INJURY	
CAUSE OF DISABILITY (TRAFFIC, WORK, SPORT, WAR, OTHER - WHAT?)	

DO NOT FORGET! IT IS IMPORTANT TO SEND TO US A PHOTOCOPY OF YOUR MEDICAL DOCUMENTATION WHERE IS STATED THAT PARAPLEGIA, QUADRIPLÉGIA, PARAPARESIS OR QUADRIPARESIS IS RESULT OF SPINAL CORD INJURY OR ILLNESS.

MEMBERSHIP IS ANNUALLY RENEWED ON JUNE 1ST. IF WE RECEIVE YOUR MEMBERSHIP FORM AFTER JANUARY 1ST, MEMBERSHIP FEE IS TO BE PAID AFTER JUNE 1ST FOR THE NEXT YEAR.

IN _____ DATE _____ SIGNATURE _____

HRVATSKA UDRUGA PARAPLEGIČARA I TETRAPLEGIČARA
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