



"Helping you to keep in touch"

Today's date: _____

Membership Form

About You:

Address: _____ First Name: _____

_____ Surname: _____

_____ Telephone No.: _____

Do you live alone?

Date of Birth: _____

Yes? No?

When would you like a call/calls from us? Time? _____

Monday Tuesday Wednesday Thursday Friday

1-5 calls per week available between: 9am -1pm & 2pm—5pm

About Your Health:

Hearing Difficulties	<input type="checkbox"/>	Speech Difficulties	<input type="checkbox"/>
Sight Difficulties	<input type="checkbox"/>	Mobility Difficulties	<input type="checkbox"/>

Are there any other details about your health that you would like us to know?

How did you hear about us? _____

About Your Contacts:

Please list below the contact details of one or two people who would be prepared to accept responsibility to check on you if your telephone is not answered when we call. (It would be helpful if one of these contacts is a key holder who has access to your home).

Name: _____ Name: _____

Address: _____ Address: _____

Telephone No.: _____ Telephone No.: _____

What is their relationship to you? _____ What is their relationship to you? _____

Key holder? Yes? No? Key holder? Yes? No?