Coeliac Society of New Zealand (Inc)

Membership Enrolment Form

PO Box 35724
Browns Bay
North Shore City 0753

Phone	09 820 5157
Fax	09 476 7251
Email	coeliac@xtra.co.nz
Website	www.coeliac.co.nz

1.	Personal Details of Coeliac	
	First name	
	Last name	
	Address	
	Suburb	
	Town/City	Post Code
	Nearest Town	
	Occupation	
	Phone no	( )
	Email	

2.	**Male** ☐ **Female** ☐ (Coeliac's gender)	3.	**Date of Birth** (of Coeliac)	☐☐ ☐☐ ☐☐☐☐ day month year

3.	Parent or Caregiver's name if above is a child	
	First name	
	Last name	

4.	**Coeliac Condition** (if different from above – ie a child)	
	Date of Biopsy	/ /
	Coeliac Condition ☐	Dermatitis Herpetiformis ☐
	Name of Specialist/Doctor	

If you have not been diagnosed by biopsy or blood test or are following a gluten free diet for any other reason please enclose a note from your medical specialist/doctor, recommending that you follow a GF diet.

5.	**Supporting Information** (please tick)			
	Are there other Coeliacs in the household?	Yes ☐	No ☐	How many ☐
	Do you wish to be contacted by your local support person?	Yes ☐	No ☐	
	Where did you obtain this form?			
	Do you wish to become a Volunteer?			

6.	**Fees** (Subscription year starts on 1 April and ends on 31 March each year)			
	New Member Joining Fee	$25.00		
	Annual Subscription	$40.00		
	TOTAL	$65.00	Donation:	$

7.	**Payment** (Please tick)	
	Cheque ☐	
	Internet ☐ (Please include your name)	Date paid _______/_______/_______
	Our Bank Account **03 1726 0020179 00**	

Signature ____________________________ *Date* _______/_______/_______

This information is retained in a confidential manner by the Coeliac Society of NZ (Inc) on their membership database.