

# Membership Enrolment Form



PO Box 35724  
 Browns Bay  
 Auckland 0753

Phone 09 820 5157  
 Fax 09 414 7468  
 Email [admin@coeliac.org.nz](mailto:admin@coeliac.org.nz)  
 Website [www.coeliac.org.nz](http://www.coeliac.org.nz)

## 1. Personal Details of coeliac

Full name			
Address			
Suburb			
Town/City	Post Code		
Current Occupation			
Phone number		Mobile	
Email (this will be used as part of your members login on our website and to communicate with you)			

2. Male <input type="checkbox"/> Female <input type="checkbox"/> (coeliac's gender)	3. Date of Birth (of coeliac)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> day month year
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## 3. Parent or Caregiver's name if above is under 16

Full name (s)	
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## 4. Coeliac Condition you are diagnosed with

Date of Biopsy: / / / or how you were diagnosed:
Coeliac disease <input type="checkbox"/> Dermatitis Herpetiformis <input type="checkbox"/>
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 gluten free diet.

## 5. Other medical conditions (please tick)

<input type="checkbox"/> Type 1 diabetes	<input type="checkbox"/> Type 2 diabetes	<input type="checkbox"/> Other autoimmune disease
<input type="checkbox"/> Thyroid condition	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Other food intolerance/allergy
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Lactose intolerance	<input type="checkbox"/> Other:

## 5. Supporting Information (please tick)

Are there other coeliacs in your household?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many <input type="text"/>
Do you wish to be contacted by your local support person/group leader?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Where did you obtain this form?			
Would you be interested in volunteering at a later date?			

## 6. Fees (Subscription year starts on 1 April and ends on 31 March each year)

New Member Joining Fee	\$30.00	(includes \$5.00 P&P)	
Annual Subscription	\$40.00		
<b>TOTAL</b>	<b>\$70.00</b>		Donation \$ <input type="text"/>

## 7. Payment (Please tick) Please make cheques payable to Coeliac New Zealand Incorporated.

<input type="checkbox"/> Cheque
<input type="checkbox"/> Internet banking (please use your name as reference)
Our Bank Account <b>03 1726 0020179 00</b> Date paid ____/____/____

This information is retained in a confidential manner by Coeliac New Zealand Incorporated on their membership database

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_