

# Membership Application Form



Please complete in legible BLOCK CAPITALS, and return with one passport photo.

I hereby apply to be accepted as a student of the Martial Arts, in the courses and sessions conducted by the Jin Long Chinese Martial Arts Academy and in consideration of being so accepted do hereby agree and undertake to fully indemnify and keep harmless the Jin Long Chinese Martial Arts Academy, its representatives, servants and agents against any loss, injury, damage costs or expenses of whatsoever description as I may suffer or incur as a result of my being injured, maimed or in the event of my death as a result of participation in such courses.

I warrant the accuracy and truth of the particulars as hereinafter appear below.

## APPLICANT'S DETAILS

Title: \_\_\_\_\_ Full name: \_\_\_\_\_

Date of birth: \_\_ / \_\_ / \_\_\_\_ Next of kin: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Post Code: \_\_\_\_\_

Telephone (Work/mobile): \_\_\_\_\_ Home: \_\_\_\_\_

E Mail: \_\_\_\_\_

How did you hear about our school?: \_\_\_\_\_



## HEALTH DECLARATION DETAILS

Do you suffer from any of the following? (indicate those from which you suffer)

- |   |                                   |   |   |
|---|-----------------------------------|---|---|
| <input type="checkbox"/> Migraine       | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> AIDS             |

Other (please give details): \_\_\_\_\_

If any of my details changes at any time, I will advise your organizer or instructor of the sessions / courses which I attend.

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_\_

(if applicant is under the age of 18 the signature of the parent or guardian is required)