



MEMBERSHIP APPLICATION

Please complete the following:

Title: Mr, Mrs, Miss, Ms, (please circle)

First name:

Surname:

Address:

.....

.....

.....

..... **Post Code:**

Telephone No:

Are you a Patient/ Relative/ Friend (please circle)

Are you interested in being on the committee ? **Yes / No**

(please circle)

THANK YOU FOR YOUR SUPPORT

There is no joining fee. Please return to:

Shetland Kidney Patients Association

Market House

14 Market Street

Lerwick

Shetland ZE1 0JP