

MEMBERSHIP APPLICATION FORM

Please accept my application to join CAV as:

A full Voting member y/n

Or as

A "Communications only" Member y/n

Name:

Address:

Email:

Telephone:

Are you a cancer:	Patient/Survivor	y/n
	Carer	y/n
	Family member	y/n
	Health professional	y/n

If you are a cancer patient or survivor then which type of cancer affected you?

Do you wish to become a Cancer Advocate to help other people affected by Cancer? y/n

Signed.....Date: / / .