



Autism Parents' Association

c/o P.O.Box 30 Marsa

Tel Nos. 79285438 / 77632787

E-mail : autismparentsassociation@gmail.com

For Office use only:

Receipt No

Membership No.

Membership Enrolment Form

Mother's name _____ ID.No _____

Occupation _____

Father's Name _____ ID No _____

Occupation _____

Address _____

Post Code _____

Tel. No. _____ Mobile No. _____ Email _____

Name and Surname of Child _____ Date of Birth _____

Diagnosis of Child _____ ID No. _____

School your child attends _____

Is he/she supported by a facilitator? _____ Shared / One to One

Other support service - *Please specify* _____

Do you have more than one child diagnosed with ASD or any other condition? Yes / No

To be completed if more than one child is diagnosed with ASD or any other condition

Name and Surname of Child _____ Date of Birth _____

Diagnosis of Child _____ ID No. _____

School your child attends _____

Is he/she supported by a facilitator? _____ Shared / One to One

Other support service - *Please specify* _____

Name and Surname of Child _____ Date of Birth _____

Diagnosis of Child _____ ID No. _____

School your child attends _____

Is he/she supported by a facilitator? _____ Shared / One to One

Other support service - *Please specify* _____

Do you have any other children? If yes please fill in the table below Siblings

Male or Female	Date of Birth	Other Info.

How did you get to know about the Association ?

Newspaper Friends Speech Therapist TV Parents School

Radio CDAU Other _____

Other Comments _____

Kindly complete this form and send to the above address together with the Membership Fee of 10 Euros. Please make cheques payable to Autism Parents' Association.

Signature/s _____ Date _____

The information you have supplied us will be treated as strictly confidential