



Australian Society of Polish Jews and Their Descendants Inc.

ASSOCIATE MEMBERSHIP FORM

Date: ___/___/___

Title _____ Given Name _____

Surname _____

Address _____

_____ Postcode _____

Phone _____ Mobile _____

Email _____

Membership Fee: \$25 p.a.

Cheque Cash

Taken by: _____

In making this application, I confirm that the above details are true and correct.

Signature _____ Date: ___/___/___

FOR OFFICE USE ONLY

Approved Date: ___/___/___