



Brainwave The Irish Epilepsy Association

249 Crumlin Road, Dublin 12 Tel: 01-4557500 Email: info@epilepsy.ie Web: www.epilepsy.ie

website

Membership Form

Membership Type

New Renewal

Please complete and return this form to us at the address above. Note: If you are renewing your membership and you have a change of address since your last renewal, please tell us your old address so that we can amend our records

Membership Category

1 Year renewal membership subscription €12.70

1 Year New membership subscription €12.70

*2 Year special membership subscription (New member only) €20

*(2 year subscription entitles a new member to a free epi-alert identity bracelet or safety pillow. See separate application form for bracelet/ pillow)

Brainwave requires this information to process your application, post membership-related material to you, and to keep you informed of events, issues, and opportunities relating to epilepsy or to the aims of the Association.

If you do not wish to receive such communication, please tick here

Voluntary Donation

I would like to help continue the work of Brainwave by making a voluntary donation to the Association

€7.30 €20 €30 €50 €100 own amount € _____

Payment Method

Credit/ Debit Card (see below)

Standing Order (see below)

Cheque/ Postal order/ Bank Draft (payable to Brainwave The Irish Epilepsy Assoc)

Total Enclosed € _____

Name of Person with Epilepsy Please use block capitals

Title _____ Name _____

Address _____

Tel No (Day) : _____ Tel No (Eve): _____ Mobile _____

E-mail _____ Date of Birth _____

I am a person with epilepsy I am the parent/ guardian of a child with epilepsy * Other _____

* Parents/ Guardians – Please enter your name here if you wish us to send all correspondence to you instead of child

Name of Parent/ Guardian for correspondence: _____

Tick here if you would like to receive our regular e-mail newsletter. Clearly write your e-mail address in the space above.

Tick here if you would like to find out more about volunteering & fundraising for Brainwave

Card Payments

I wish to pay by: Visa Mastercard Laser and I authorise you to debit my account with the sum of € _____

Name on Card _____

Card Number _____ Expiry Date (mm/yy) _____ CVV No _____

Signature _____ Date _____

Standing Order Please return this part of the form to us. Do not detach

Bank _____ Branch _____

Account No _____ Sort Code _____

Please pay the sum of € _____ to the Account of the Brainwave The Irish Epilepsy Association at Bank Of Ireland, Walkinstown, Dublin 12, Account Number 88644504, Sort Code 90-02-87 on this date and on the corresponding date each succeeding year until further notice.

Signed _____ Date _____