

APPLICATION FOR MEMBERSHIP OF AWTTA

YEAR: _____

NAME

Address

Phone

Email

DOB

Emergency Contact Person

Name

Address

Phone

Do you have any disability of which we should be aware?

Please describe

Do you have any medications/ailments/wishes that would preclude any of the following

Emergency first aid

Defibrillator

Resuscitation

Do you consent to first aid being administered if deemed necessary?

YES

NO

(circle choice)

I agree to abide by all the constitution and bylaws of the AWTTA.

Signed

Date