Ciliopathy Alliance

Promoting care and improved quality of life for those with ciliary diseases

# APPLICATION FOR MEMBERSHIP OF THE CILIOPATHY ALLIANCE

**1. Which category of membership are you interested in** *(Please tick ✓)*

☐ **Full (Organisation)**
(Legally constituted non-profit patient organisation)

☐ **Associate (Individual)**
(Individual who promotes and/or takes part in the activities of the Ciliopathy Alliance

☐ **Affiliate (Organisation)**
(Patient organisation not yet legally constituted)

☐ **Associate (Organisation)**
(Organisation which promotes and/or takes part in the activities of the Ciliopathy Alliance

**2. Your organisation – if you are applying for organisational membership**

Organisation name: .....

Primary contact name: .....

Ciliopathies represented: .....

E-mail ..... Website .....

Telephone ..... Post/zip code .....

Address .....

City ..... Country .....

**3. If this is a patient organisation, what is your role** *(Please tick ✓)*

☐ Patient ☐ Staff

☐ Parent of patient ☐ Trustee/Director

☐ Medical adviser ☐ Volunteer

If your organisation is a legally constituted, non-profit or charity, please provide the registered number .....

What is the turnover of your organisation .....

**4. Your personal details - if you are applying as an individual**

First name ..... Last name .....

E-mail ..... Telephone .....

Address ..... Post/zip code .....

City ..... Country .....

Signature (individual or authorised representative) Date of Application

..... .....

Please sign and email back to info@ciliopathyalliance.org