

Membership Application Form

Name: _____

Organisation: _____

Address: _____

Tel: _____ Email: _____

Primary Contact Person: _____ Role: _____

I have read and agree to subscribe to the Vision and Mission of Care Alliance Ireland.
(See <http://www.carealliance.ie/vision-and-mission>)

Signature: _____ Date: _____

(Typed signature accepted)

Governance is an important aspect in the consideration of applications for membership, both for Care Alliance Ireland and its Directors. Care Alliance may request supporting documentation for governance purposes on receipt of your membership application. Following board consideration of the application, and assuming it is approved, we will issue an invoice to the email supplied above for the membership fee of €25 per annum. Our preference is for payment by online bank transfer.

Please return to: Care Alliance Ireland, Coleraine House, Coleraine Street, Dublin 7
Or by email to: info@carealliance.ie

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E info@carealliance.ie
W www.carealliance.ie

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Charity Registration No
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