



**Membership Application Form**

Send this form to info@sbbv.co.za

Complete in neat handwriting and clear block letters

**Membership Type**

Mark with X

<b>Active Member</b>	<b>Non-active Member</b>	<b>Corporate member</b>
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**Active Member:** Help fight fires. Complete all sections excluding section 6.

**Non-active Member:** Member with residential properties. Not fighting fires. Complete Sections 1 and 5.

**Corporate Member:** Member with business property/ Agricultural holdings/ rural property/ government institution. Not fighting fires. Complete sections 1, 5 and 6.

**Member/ Applicant Details Section 1**

Full Names:

Surname:

Preferred Name:  Date of Birth:

ID Number:  Age:

Marital Status:  Married  Single  Widowed Gender:  Female  Male

Home Language:  Second Language:

Cellphone Number:  Email:

Home Tel Number:  Work Tel Number:

Home Address:   
  
 Postal Code:



**Sinoville Fire Fighting Association**  
**Membership Application Form**

Contact number: 071 409 9251

**Member Employment Details Section 2**

Occupation/Nature of Business:

Employer:

Employer's Registered Name with the Compensations Commissioner:

Employer's Registered Number with the Compensations Commissioner:

Employer Address:   
  
 Postal Code:

**Member's Medical Details Section 3**

Doctor's Name:	<input type="text"/>	Dr Contact No:	<input type="text"/>
Medical Aid:	<input type="text"/>	Medical Aid Number:	<input type="text"/>
Main Member:	<input type="text"/>	Member's Ref Number:	<input type="text"/>
Main Member ID:	<input type="text"/>	Benefit Option:	<input type="text"/>
Member's Blood Type:	<input type="text"/>		
Allergies:	<input type="text"/>		

**Medical Background Section 4**

Does the member suffer from any Chronic medical condition?  Yes  No

Is the member receiving any medical treatment for a condition?  Yes  No

Has the member received any operations or medical procedures in the last 6 months?  Yes  No

Does or has the member suffered from any disabilities?  Yes  No

Does the member have any special needs/ prosthetic limbs/ hearing aids?  Yes  No

Qualified Medic/Paramedic?  Yes  No      Qualified Fire Fighter?  Yes  No

Please specify any other medical information:



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**Next of Kin/Emergency Contact 1 Section 5**

Full Name:			
Surname:			
Preferred Name:		Relationship:	
Living with Member:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cellphone Number: <input type="text"/>
Home Number:	<input type="text"/>	Work Number:	<input type="text"/>
Home Address:	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>	Postal Code:	<input type="text"/>

**Next of Kin/Emergency Contact 2 Section 5**

Full Name:			
Surname:			
Preferred Name:		Relationship:	
Living with Member:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cellphone Number: <input type="text"/>
Home Number:	<input type="text"/>	Work Number:	<input type="text"/>
Home Address:	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>	Postal Code:	<input type="text"/>

