

LEICESTER CITY DISABILITY SUPPORT ASSOCIATION

DECLARATION OF DISABILITY

L.C.F.C. DISABILITY SUPPORT ASSOCIATION MEMBERSHIP APPLICATION FORM
2021 to 2024

SURNAME:

MR/MRS/MS/MISS

Date of Birth:

FIRST NAME (S):

KNOWN AS (IF DIFFERENT)

IF APPLYING FOR A CHILD UNDER 18 A PARENT OR GUARDIAN MAY COMPLETE AND SIGN BELOW

Please tick below

Do you receive Disability Living Allowance

Do you receive a PIP (Personal Independence Payment)?

Do you receive War Pensioners Disablement Benefit?

Do you receive Severe Disablement Allowance or Employment Support Allowance?

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Do you receive Attendance Allowance?

Are you Registered Blind/Visually Impaired?

Do you have a Blue Badge Parking Permit?

Other (Please specify)

*****Please supply a photocopy of the relevant proof*****

*****ONLY ONE FORM OF PROOF NEEDED.*** All copies will be destroyed after processing.**

Do you occupy/need a wheelchair space at the King Power Stadium? _____

IF NOT, Do you use any mobility aids i.e Wheelchair/Sticks/Crutches? Please stat _____

Do you attend with a companion/carer? _____

If YES, is your companion/carer able bodied? _____

I enclose a cheque for my joining fee of £25. _____

I have submitted my joining fee of £25 by bank transfer. _____

I have also enclosed/transferred an additional fee of £7.50 for my companions Carer Card.

I declare that the information given is correct, and if there are any changes in my details or circumstances, I will inform the DSA Membership Secretary at: lfcdsa@gmail.com or tel 07946750063.

I also consent to the LCFC DSA holding my personal data solely for the benefits of membership and contacting me by email, letter, text or phone or by social media for all Association related matters. (Required)

I also agree that the DSA may use my image or data for the purpose of promoting the DSA on it's social media pages and website. (but will never reveal my age, contact details, or medical and social records.) Optional, please tick. []

SIGNED or SIGNED ON BEHALF: _____

PRINT NAME _____ DATE _____

EMAIL ADDRESS _____ MOBILE No. _____

ALL APPLICANTS MUST COMPLETE AND RETURN THIS PAGE.

Find us on  LCFC Disability Support Association  @LCFCDSA **WEBSITE:** www.lfcdsa.com
email: lfcdsa@gmail.com **Tel:** Judith (Secretary) 07946 750063/Sandra (Chairman) 07800 652943

COMPANION/CARER DETAILS FORM

1ST COMPANION/CARER

SURNAME:	MR/MRS/MS/MISS
FIRST NAME (S):	KNOWN AS (IF DIFF)
ADDRESS	
	POST CODE:
HOME TEL NUMBER:	MOBILE:
EMAIL ADDRESS:	
DATE OF BIRTH:	
RELATIONSHIP TO DISABILITY MEMBER:	

2ND COMPANION/CARER

SURNAME:	MR/MRS/MS/MISS
FIRST NAME (S):	KNOWN AS (IF DIFF)
ADDRESS	
	POST CODE:
HOME TEL NUMBER:	MOBILE:
EMAIL ADDRESS:	
DATE OF BIRTH:	
RELATIONSHIP TO DISABILITY MEMBER:	

**PLEASE ONLY COMPLETE THIS PAGE IF A CARER CARD IS NOT REQUIRED
AND/OR YOU WISH TO LIST A SECOND COMPANION**