

**LCGB MEMBERSHIP APPLICATION FORM**

TITLE.....SURNAME.....

FIRST NAME.....

HOME ADDRESS.....

.....POSTCODE.....

TELEPHONE: HOME.....WORK.....

EMAIL ADDRESS.....

PLACE OF WORK.....

POSITION HELD.....

VOLUNTARY ROLE.....

INTEREST OR EXPERTISE.....

**BREASTFEEDING CLINIC OR SUPPORT GROUP**

NAME.....DAY.....TIME.....

VENUE.....

YEAR IBCLC.....RECERTIFIED.....

ABLE TO ACCEPT REFFERRALS                      YES.....NO.....

PRIVATE PRACTICE                                      YES.....NO.....

a) AS AN IBCLC, I WISH TO BECOME A FULL MEMBER OF LCGB.....

b) I WISH TO BECOME AN ASSOCIATE MEMBER OF LCGB.....

FEES: **£30** PER YEAR IF COMPLETING A STANDING ORDER FORM.....

To download Standing Order Form    [http://www.lcgb.org/images/LCGB\\_StandingOrder.pdf](http://www.lcgb.org/images/LCGB_StandingOrder.pdf)

**£36** PER YEAR IF CHOOSING TO PAY BY CHEQUE (to LCGB).....

SIGNATURE.....DATE.....

**FORWARD APPLICATION FORM & METHOD OF PAYMENT TO:**

**SHEILA COMPANY  
MEMBERSHIP SECRETARY  
9 CAMPBELL CLOSE,  
YATELEY,  
HANTS  
GU46 6GZ**

**THANK YOU**