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

SIGNATURE………………………………………………………DATE……….……

FORWARD APPLICATION FORM & METHOD OF PAYMENT TO:

SARAH GILL IBCLC
MEMBERSHIP SECRETARY
9 CHAWORTH ROAD
WEST BRIDGFORD
NOTTINGHAM
NG2 7AE
THANK YOU