

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).....

I agree to acknowledge and accept the principles and standards of IBLCE and the IBCLC credential:

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

Where did you hear about LCGB?.....

FORWARD APPLICATION FORM & METHOD OF PAYMENT TO:

**ROS WHITE
MEMBERSHIP SECRETARY
8 STATION ROAD
WALMER
DEAL
KENT
CT14 7QR**

THANK YOU