**COPD Support Ireland Membership Form**

I wish to become a Member of COPD Support Ireland Yes [ ]  No [ ]

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Eircode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am a COPD Patient Yes [ ]  No [ ]

I am a family member of a COPD Patient Yes [ ]  No [ ]

I wish to be included on the COPD Support Ireland mailing List Yes [ ]  No [ ]

I wish to join a local COPD Support Group Yes [ ]  No [ ]

I give permission for COPD Ireland to hold my personal details on file for the purposes of Registration, Communication and Administration. Yes [ ]  No [ ]

**My preferred contact method:**

E-mail [ ]  Phone[ ]  Text [ ]  Post [ ]  (Please tick as many as you wish )

**Member Consent Form**

**Please Circle Yes or No as appropriate**

**For the duration of your membership, we request your informed consent to the following:**

1. **\*Member\*** I understand that COPD Support Ireland will collect, use, and share relevant personal information e.g. contact details, CAT score and Exercise Tolerance test results, with the relevant third parties delivering COPD Support Ireland services and classes. **Yes/No**
2. **\*Member\*** I consent to Data of my Exercise Testing and CAT scores being retained and used for monitoring and evaluating my progress as well as service improvement and development within COPD Support Ireland- **Yes/No**
3. **\*Member\*** I take full responsibility for my own health, well-being and safety for the duration of these exercise classes- **Yes/No**
4. **\*Member \*** I hereby acknowledge I am in good health to attend the COPD Support Group Exercise Classes; and consent with full knowledge that with the advice of my healthcare practitioner I can take part in these classes within my own capabilities- **Yes/No**
5. **\*Member\*** If in the case of a medical emergency, the trainer/facilitator of the class may release information to the emergency services/treating party- **Yes/No**
6. I consent to receive COPD Support Ireland emails/text messages/news/updates-**Yes/No**
7. I can confirm that I suffer from COPD- **Yes/No**
8. If you do **NOT** suffer from COPD, what is the condition/reason for your joining COPD Support Ireland?

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**\*Member\*** I understand and agree with the above statements and as such agree to become a member of COPD Support Ireland. My consent is voluntary and ongoing, commencing on the date below. I understand that I may ask questions at any time, and that my consent to the above may be withdrawn in writing at any time, except for actions already taken.

Members Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Person Details**

If in the case of a medical emergency whilst undertaking one of our classes / meetings we may need to contact someone on your behalf. Please provide contact details for the person you would wish us to contact.

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Phone No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_