MEMBERSHIP FORM
For a Person With an Ataxia

Name: .....

Address: .....

.....

Tel: ..... Mobile: .....

E-mail: ..... Date of Birth: .....

Would you be interested in participating in a Clinical Trial in Ireland?
Please tick relevant box

☐ Yes ☐ No

Type of Ataxia:

☐ Friedreich's Ataxia

☐ Cerebellar Ataxia

☐ Episodic Ataxia

☐ Other

Genetic Diagnosis ☐ Yes ☐ No

Any other information in relation to Diagnosis (i.e SCA No.)

.....

Date of First Symptoms: .....

Neurologist: ..... Hospital: .....

Please send information to me by: Post ☐ E-mail ☐

Signed: ..... Date: .....

Membership No. ..... *(office use only)*

Please Note: Membership does not imply you cannot be a member of any other organisation and membership is Free

Ataxia Foundation Ireland, Gorteen, Inch, Gorey, Co. Wexford. Y25 XP66
W: www.afi.ie E: info@afi.ie M: 087- 361 6616 Co. Reg: 588973