



## MIDLANDS AIDS CARING ORGANISATION MEMBERSHIP APPLICATION FORM

### Personal Information:

Full Name: .....

ID. No:.....

Date of Birth:.....

Gender: .....

Address:.....

City: .....

Email: .....

Phone Number: .....

### Payment Information:

Fee: us\$10 or Equivalent

Payment Method: Cash { } Bank Transfer { } Online Payment { }

### Membership Details:

Are you currently a member of any other organizations? [Yes/No]

If yes, please specify: \_\_\_\_\_

Reason for joining Midlands AIDS Caring Organisation: \_\_\_\_\_

**Declaration:** I hereby declare that the information provided above is true and accurate to the best of my knowledge. I understand the membership terms and agree to abide by the rules and regulations of the Midlands AIDS Caring Organisation.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please submit your completed form to the Midlands AIDS Caring Organisation office or email it to [director@maco.org.zw](mailto:director@maco.org.zw) . Thank you for your interest in joining our organization and supporting our cause.