



SLEEP APNOEA TRUST ASSOCIATION

NON MEMBER

MEDICAL ALERT CARD POSTAL APPLICATION FORM

Please complete the form in capital letters.

TITLE:		FIRST NAME:		LAST NAME:	
ADDRESS:					
POST CODE:		TEL:		EMAIL ADDRESS:	
CLINIC:		COMPLAINT: (tick box)	Obstructive Sleep Apnoea (OSA) <input type="checkbox"/>	CPAP USER SINCE:	
			Central Sleep Apnoea (CSA) <input type="checkbox"/>		
			Nocturnal Hypoventilation (NH) <input type="checkbox"/>		

Please supply me with a Medical Alert Card @ £10.00	£
I would like to make a donation to the Sleep Apnoea Trust	£
<p style="text-align: right;">TOTAL</p> By Post – Please enclose a cheque/PO payable to the Sleep Apnoea Trust Direct Bank Transfer - A/c Name: Sleep Apnoea Trust \ A/c No: 83589805 \ Sort Code: 60-11-01 NB: Please quote surname and postcode as the payment reference for our administration.	£

If you wish to apply and pay on line, please visit our website and choose the
Join SATA/ Request MA Card button

www.sleep-apnoea-trust.org

Please return this form together with your payment to:
SATA, PO Box 60, Chinnor, Oxon, OX39 4XE