*(For Office Use)*

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# HANDICAPS WELFARE ASSOCIATION
# 残 疾 人 士 福 利 协 会

16 Whampoa Drive, Singapore 327725
Tel: 62543006 Fax: 62537375
Email: hwa@hwa.org.sg
Website: http://www.hwa.org.sg

## MEMBERSHIP APPLICATION FORM
## 会 员 申 请 表 格

I wish to apply for Ordinary / Associate* Membership of the Association and agree to abide by the rules and regulations governed by the Constitution of the Association.
我希望申请成为贵协会的普通 / 准 * 会员，并遵守贵协会的条规和宪法。

## I) APPLICANT PARTICULARS
## 个 人 资 料

*(Please put "X" where applicable and *delete where not applicable*
*请在适当的项目打个 "X" 及 * 删去不适用之处)*

Full Name: **Mr / Miss / Mdm / Mrs / Dr***
英文姓名之全名：先生 / 小姐 / 女士 / 太太*
(as in NRIC / Passport*, in BLOCK Letters and Underline Surname)
(与身份证 / 护照*一样，请用英文大写且在姓氏下划线)

**TO AFFIX PHOTOGRAPH**
**请贴上照片**

Alias (If any)：
别名(如有)

Name in Chinese Characters (If applicable)：
中文姓名(若有)

*Sex：
性别

M 男 | F 女

NRIC/Passport*No：
身份证 / 护照 * 号码

Date of Birth：
出生日期

Address：
地址

Nationality：
国籍 _____

Marital Status:
婚姻状况
☐ Single 单身 ☐ Married 已婚 ☐ Separated 分居 ☐ Divorced 离异 ☐ Widowed 丧偶

Race:
种族
☐ Chinese 华人 ☐ Malay 马来人 ☐ Indian 印度人 ☐ Eurasian 欧亚混血儿

☐ Others: _____
其他

Religion: 宗教
☐ Buddhism 佛教 ☐ Christianity 基督教 ☐ Hinduism 兴都教 ☐ Islam 回教 ☐ Taoism 道教

☐ Roman Catholic 天主教 ☐ Freethinker 无宗教 ☐ Others: 其他 _____

Home Tel. No.: 6 住家电话号码 | | | | | | | |

Office Tel. No.: 6 办公室号码 | | | | | | | |

Handphone No.: 9 手提电话号码 | | | | | | | |

Pager No.: 9 传呼机号码 | | | | | | | |

Email Address (If any): 电子邮件(若有) _____

## II) LANGUAGES WRITTEN AND SPOKEN
## 书写及会话语言

| Written Languages : 书写语文 | Spoken Languages & Dialects / Others : 会话语言及方言 / 其它 |
|---|---|
| | |

## III) NATURE OF DISABILITY
## 残障状况

State Nature of Disability : 请注明残障状况

Cause of Disability : 残障原因

☐ Congenital (Since birth) / Genetic 天生 / 遗传

☐ Illness / Accident / Others* : 疾病 / 意外 / 其它* _____

Type of Accident : Traffic / Work / Recreational / Home* 意外类型: 交通 / 工作 / 娱乐 / 家内*

Date on Disability : 残疾发生日期 _____

Do you use any mobility aid? If YES, please state the type(s) (eg. crutches, calipers, wheelchair, etc.) 您是否需用步行辅助器? 若需, 请注明种类 (如拐杖, 弯脚器, 轮椅等等)

**Please delete where not applicable* 请删去不适用之处

**NOTES**
**备注**

1. Ordinary Membership shall be opened to any person with a physical disability and who is a Singapore Citizen between the age of 16 and 60 years old at the time of application.
普通会员将开放给体障人士，但需是新加坡公民，及在申请时年龄介于十六及六十岁之间。

2. Associate Membership shall be opened to all other persons with physical disability who is not a Singapore Citizen between the age of 16 and 60 years old at the time of application.
准会员将开放给所有其他不是新加坡公民的体障人士参加，但在申请时年龄需介于十六及六十岁之间。

3. Subscriptions of Memberships (*According to the Constitution*):
会员费(根据宪章)

| | |
|---|---|
| **ORDINARY MEMBER**<br>普通会员 | **$10.00**<br>**($5.00 per annum and $5.00 entrance fee)**<br>十元(每年五元，另加入会员五元) |
| **ASSOCIATE MEMBER**<br>准会员 | **$20.00**<br>**($10.00 per annum and $10.00 entrance fee)**<br>二十元(每年十元，另加入会员十元) |

4. Please enclose your subscription fee upon submission of this application form.
在呈交申请表格时，请付上会员费。

5. Application is subject to approval by the Executive Committee of the Handicaps Welfare Association.
残疾人士福利协会的执行理事会有权决定申请是否被批准。

Completed applications are to be forwarded to :-
填妥的申请表格请寄交

The Honorary Secretary
**HANDICAPS WELFARE ASSOCIATION**
16 Whampoa Drive
Singapore 327725
Tel: 62543006 Fax: 62537375

**FOR OFFICE USE ONLY**
**只供办公室用**

**Remarks:**

Date of Approval / Disapproval*: _____

_____ Honorary Secretary

_____ President

**Please delete where not applicable* 请删去不适用之处

## IV) EDUCATIONAL QUALIFICATION / SKILLS
## 教育资格 / 技能

| Please Specify Highest Standard Passed.<br>请注明所获取的最高教育资格 | Other Qualifications / Skills Possessed (Please elaborate):<br>其它资格 / 技能 (请注明) |
|---|---|
| ☐ No Formal Education<br>没受过正统教育<br><br>☐ Special Education<br>特别教育<br><br>☐ Formal Education (eg. PSLE, GCE"O", GCE"A", Diploma, Degree):<br>正统教育(如小六文凭，普通剑桥水准文凭，高级剑桥水准文凭，大专文凭，大学学位):<br><br>_____ | |

## V) EMPLOYMENT STATUS
## 工作状况

| |
|---|
| Current Occupation：<br>目前职业 |
| Employer & Place of Work：<br>雇主及工作地点 |
| If unemployed, state previous employment：<br>若目前没工作，请注明最后一份职业与停职日期 |

## VI) GENERAL INFORMATION
## 其它详情

| |
|---|
| Are you a member of any organisation? *Yes / No<br>您是不是其它机构的会员？*是 / 否<br><br>If yes, please specify: _____<br>若是，请注明 |
| What are your hobbies and interest ?<br>您有那些嗜好和兴趣 |
| Do you have any problem getting out of the house? If yes, why?<br>当您想从住家出来，您是否遭遇任何困难？如是，为什么？ |

**Please delete where not applicable* 请删去不适用之处

## VII) DECLARATION
## 宣 誓

I 我, _____ , declare that the information provided is correct to the best of my knowledge. I accept the rules set by HWA that once my disability condition has sufficiently recovered, the Association has the right to terminate my membership.

在此宣誓所提供的资料是正确的。同时，我也接受协会所订下的条例，一旦我的残疾状况充分地复原时，协会有权终止我的会员籍。

_____ _____

Signature / Thumb Print* of Applicant
申请者签名 / 打手印*

Date
日期

## VIII) PROPOSER AND SECONDER OF APPLICATION
## 提 议 及 附 议 处

Membership application can only be proposed and seconded by members of the Association.
此会员申请只有协会之会员才可提议及附议。

_____ _____

Name of Proposer
提议者姓名

Name of Seconder
附议者姓名

_____ _____

Signature / Thumb Print* of Proposer / Date
提议者签名 / 打手印* / 日期

Signature / Thumb Print* of Seconder / Date
附议者签名 / 打手印* / 日期

**Please delete where not applicable* 请删去不适用之处

## IX) DOCTOR'S CERTIFICATION
## 医生证明处

**Diagnosis:** *(Please use medical terminology)*

**Nature of Disability: Physical / Intellectual / Mental / Others***

Remarks: _____

**Is the Disability Permanent? Yes / No***

Remarks: _____

**Cause of Disability** *(Please indicate at the appropriate box)*

Date on Disability : _____

☐ Congenital / Genetic

☐ Accident Traffic / Work / Recreation / Home / Others* _____

☐ Illness Please specify: _____

☐ Others Please specify: _____

**Other Associated Medical Problem(s):** (If any)

**Mobility / Independent Living Aids Used / Recommended:**

I certify that the above applicant, whose nature of permanent functional / structural limitation falls within the Association's definition of disability:

***" Handicap is defined as a disadvantage for a given individual resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal, depending on age, sex, social and cultural factors for the individual."***

_____ _____

Name of Physician Signature

_____ _____

Name of the Hospital / Clinic Date

*(Company stamp)*

**Please delete where not applicable* 请删去不适用之处