



LIBRARY MEMBERSHIP FORM

Surname:

First name:

Title:.....

Address:.....

.....

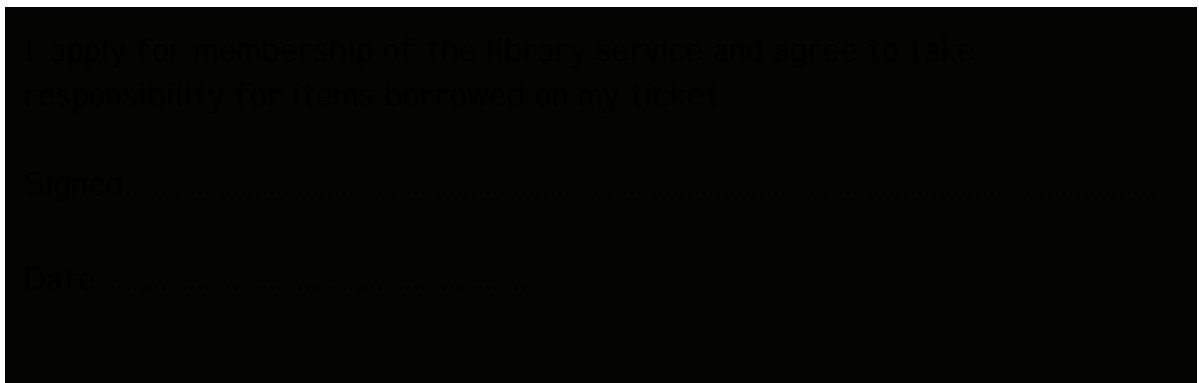
Post Code:

Tel:.....

E-mail:.....

Date of Birth:.....Age:.....

Please complete the information overleaf





LIBRARY MEMBERSHIP FORM

Equal Opportunities (please tick)

- | | |
|--|---|
| White - British <input type="checkbox"/> | Asian or Asian British - Bangladeshi <input type="checkbox"/> |
| White - Irish <input type="checkbox"/> | Asian or Asian British - Indian <input type="checkbox"/> |
| White - other <input type="checkbox"/> | Asian or Asian British - Pakistani <input type="checkbox"/> |
| Chinese <input type="checkbox"/> | Asian or Asian British - other <input type="checkbox"/> |
| Mixed white and Asian <input type="checkbox"/> | Black or black British - African <input type="checkbox"/> |
| Mixed white and Black African <input type="checkbox"/> | Black or Black British - Caribbean <input type="checkbox"/> |
| Mixed - other <input type="checkbox"/> | Black or Black British - other <input type="checkbox"/> |

In which language do you prefer to read :

.....

Do you consider yourself to have a disability?

.....

