



HWA
Impacting Lives . Bridging Communities

Handicaps Welfare Association

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Email: hwa@hwa.org.sg
Website: <https://hwa.org.sg>

For official use:

Membership Application Form

I wish to apply for

- Ordinary Membership
 Associate Membership

I agree to abide by the rules and regulations governed by the Constitution of the Association.

To Affix
Photograph

Personal Information

Name		NRIC / FIN <i>(only last 4 digits)</i>	Citizenship	
Address		Blk / Bldg	Unit No.	Postal Code
Date of Birth <i>(dd/mm/yyyy)</i>	Phone Number	Mobile Number	Email Address	
Race <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Eurasian <input type="checkbox"/> Malay <input type="checkbox"/> Others: _____		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced		
Religion		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		

Languages Written and Spoken

Written Languages	Spoken Languages
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Other Information

Are you a member of any organization? <input type="checkbox"/> Yes or <input type="checkbox"/> No <i>If yes, please state the name of the organization(s)</i>	Why do you want to join HWA?
Are you interested to join other organization? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, HWA will discuss with you accordingly)	

Other Contact(s) in case of emergency

Name (Primary)

Contact Number

Email Address

Relationship

Name (Secondary)

Contact Number

Email Address

Relationship

Educational Qualification / Skills

Education Qualification	Year Attended	Skills Certification	Year Attended

Employment Status

Current Occupation

Industry

Employer Name (*optional)

If unemployed, state the nature of previous employment. (kindly write **N/A** if not applicable)

Last Year of Employment
(dd/mm/yyyy)

Doctor Certification

Patients Name

Date (dd/mm/yyyy)

Diagnosis (Please use medical Terminologies)

Certify the nature of disability

Physical Sensory Intellectual Developmental

Is the disability permanent?

Yes No

Disability

Date of Onset (dd/mm/yyyy)

Cause:

- | | |
|--|--|
| <input type="checkbox"/> Accident (Traffic) | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Accident (Industrial) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Accident (Others) | <input type="checkbox"/> Virus Attack |
| <input type="checkbox"/> Brain / Nerve Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Congenital | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Degenerative Disease | <input type="checkbox"/> Others; specify _____ |
| <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Head Injury | |

Mobility / Independent Living Aids Used / Recommended:

Other Associated Medical Problem(s): (if any)

I certify that the applicant's nature of disability falls under the Association's accepted definition of disability, that is:

A disability is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. (World Health Organisation).

'Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others' (UNCRPD, 2006).

Name of Physician

Signature

Name of the Hospital / Clinic
(Company Stamp)

Declaration and Consent

By signing this membership application form;

I declare that information provided is correct to the best of my knowledge.

I agree that Handicaps Welfare Association (HWA) may collect, use and disclose my personal data, as provided in this application form, or (if applicable) obtained by the association as a result of my membership, for the following purposes in accordance with the Personal Data Protection Act 2012 and HWA's data protection policy.

(Available at HWA website <http://www.hwa.org.sg/corporate-governance-disclosure/>).

- (a) processing of this membership application;
- (b) administration of my membership with HWA;
- (c) case management and assessments for HWA services;
- (d) contacting me for HWA related events, projects, programmes & volunteering engagements;
- (e) photos or videos taken during service, HWA events, or partnered events will be used for HWA publicity purposes.
- (f) referral to external agencies when required

Name

Signature

Date (dd/mm/yyyy)

Please visit our website at <https://hwa.org.sg/corporate-governance-disclosure/> for further details on HWA's data protection policy, including how you may access and correct your personal data or withdraw consent to the collection, use or disclosure of your personal data.

NOTES

1. Ordinary Membership shall be opened to any person with a physical disability and who is a Singapore Citizen between the age of 18 and 70 years old at the time of application.
2. Associate Membership shall be opened to all other person with physical disability who is not a Singaporean Citizen between the age of 18 to 70 years old at the time of application.
3. Subscriptions of Membership (According to the Constitution)

Ordinary Member	\$10.00 (\$5.00 per annum and \$5.00 entrance fee)
Associate Member	\$20.00 (\$10.00 per annum and \$10.00 entrance fee)

4. Please enclose your subscription fee upon submission of this application form
5. Application is subject to approval by the Executive Committee of Handicaps Welfare Association

For Official Use

Remarks

Date of Approval / Disapproval*: _____

Honorary Secretary

President