



Name:
Isem: (name of parent if Coeliac is under 18; isem tal-genitur jekk is-Coeliac huwa taht is-18 il-sena)

Name of child:
Isem tat-tifel/tifla: (imla biss jekk is-Coeliac huwa taht is-18 il-sena)

Address:
Indirizz:

Town: Post Code:
Belt/Raħal

Tel. No: Mobile. No. E-mail Address:

Coeliac’s Date of Birth: I.D.No.
Data tat-twelid tas-Coeliac I.D. Card

Age when diagnosed:
Eta’ meta saret id-djanjosi

Consultant:
Konsulent:

Important: Has Coeliac been diagnosed by a biopsy? Yes No
Importanti: Lis-Coeliac saritlu biopsy? Iva Le

Date when Biopsy was carried out:*copy of medical certification needs to be attached*
Data tal-Biopsy *ibgħat kopja taċ-ċertifikat mediku mal-formola*

Circulars: (state language preference) Maltese English
Cirkolarijiet: (b’liema lingwa tippreferi) Malti Ingliz

State whether you wish to receive medical information (English only) Yes No
Tixtieq informazzjoni medika (bl-Ingiliz biss) Iva Le

Membership Fee: €14. -- Renewable every January of each consecutive year
Miżata tas-Sħubija: Is-sħubija tigidde f’Jannar ta’kull sena

PAYMENT: EITHER by money order or cheque payable to “COELIAC ASSOCIATION MALTA”
OR the equivalent in € 0.26 stamps (no other denomination is accepted).
Hlas: B’cekk jew money order lis-COELIAC ASSOCIATION MALTA
JEW permezz ta’bolli ta € 0.26 (kull tip ta bolla oħra ma tiġix accettata)

NOTE: If you would like to affect payment through Internet Banking, please contact the Treasurer on 79815671 or email him for further instructions on: george@coeliacassociationmalta.org

NOTA: Għal-aktar dettalji biex tkun tista’ thallas permezz tal-Internet Banking, ikkuntattja lit-Teżorier fuq 79815671 jew b’emailf’indirizz: george@coeliacassociationmalta.org

Signature/Firma: Date/Data.....

Send this form together with payment to:
Ibghat din il-formola flimkien mal-ħlas tas-sħubija lil:

Coeliac Association - Malta
PO BOX 72, Manwel Dimech Street,
Sliema SLM 1055