



SEFF MEMBERSHIP APPLICATION



Official Use: S/S - D/B - Text Service - Email - Fees - GDPR - Scanned - Referral Date - _____ Other - _____

Total fees pd: £ _____ Date pd: _____ Year of Membership: 20_____ to 20_____ Gift Aid: **Yes** or **No**? **Approved - Y - N - M.I**

Please complete the below information to the best of your ability and in BLOCK CAPITALS. The information you provide on this form will be used to register you on SEFF's member database and to provide relevant services for you. Further information on our GDPR policy, can be found at www.seff.org.uk.

FIRST APPLICANT DETAILS

Title: _____ Name & Surname: _____

Date of birth: _____ **Mother's Maiden Name:** _____

Address & Town _____

County: _____ Post Code: _____ District Council: _____

Home Tel No: _____ **Email Address:** _____

Mob No: _____ **Gender:** Male Female Transgender

Relationship Status: **MARRIED – WIDOWED – SINGLE – DIVORCED – SEPERATED – CO-HABITING** (PLEASE CIRCLE APPROPRIATE)

APPLICANTS COMMUNITY BACKGROUND

Protestant: _____ Roman Catholic: _____ Other: _____

EMPLOYMENT STATUS (PLEASE TICK APPROPRIATE BOX)

Employed F/T Employed P/T: _____ Unemployed: _____

Student: _____ Retired: _____ In Training: _____ Self Employed: _____

CIRCUMSTANCES (TICK MULTIPLE BOXES IF APPROPRIATE)

Are you a Carer of someone as a consequence of The Troubles? Or Bereaved of family member due to the Troubles?

If bereaved please give name of deceased: _____ Date of death: _____

Immediate Family Extended Family Multiple Losses

Have you been: -
Physically Injured Witness – (1 Incident) Witness – (Multiple Incidents)
Displaced or Forced Relocation Intimidated Psychologically Injured (Other)

Please give details of incident(s)/circumstances **important** (provide as much information as possible including **DATES & LOCATIONS**)

Large empty text area for providing details of incidents/circumstances.

SEFF Services Required: Health & Wellbeing Support Befriending Counselling Advocacy

Morning SEFF Calling Social Support Welfare Advice Volunteering Complementary Therapies

Therapies Provided: Reflexology Massage Aromatherapy Indian Head Massage Physio Health Kinesiology Hopi Ear Candle (please circle)

How would you prefer to receive the SEFF monthly Newsletter: Via Regular Post Or EMAIL: Please provide email address above

Your G.P Name - _____

G.P Surgery Address _____

G.P Contact No - _____

PLEASE REMEMBER TO COMPLETE GDPR PERMISSIONS ON REVERSE – SEFF NEEDS YOUR CONSENT TO HOLD YOUR DATA ON OUR SYSTEMS

EMERGENCY CONTACT (NOT YOUR SPOUSE IF BOTH REGISTERING WITH SEFF)

Name:	Relationship:
Phone:	Mob:

SPOUSE/PARTNER DETAILS (LIVING AT SAME ADDRESS)

Title:	Name & Surname:
Date of Birth:	Mother's Maiden Name:
Contact No:	Email Address:
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/>	Relationship Status:

EMPLOYMENT STATUS

Employed F/T	Employed P/ T:	Unemployed:	Student:	Retired:	In Training:	Other:
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Do you have any health issues that we need to be aware of?.....

Who referred you to this group? I chose to come here myself The VSS referred me Other (Please State)

CHILDRENS DETAILS

Name	DOB	Age	Gender	Mother's Maiden Name

SIGNATURES

In the context of 'The Northern Ireland Troubles,' I/We acknowledge the futility of violence and am agreed that the use of violence in the furtherance of or defence of a political objective was/is wrong and unjustified.

Signature of applicant:	Date:
Signature of Spouse (<i>only if joint application</i>)	Date:

Membership year starts 1st April to 31st March each year from 2021

Membership Fee: Adults £10 each - Post Primary up to 16yrs £5 each - Child up to 11yrs FREE

Under Data Protection Law, do you authorise **SEFF** to hold your data for the duration of your membership in SEFF? **YES** **NO**

Do you give SEFF consent for your photo to be used by **SEFF** for advertising and social media formats? **YES** **NO**

ARE YOU A MEMBER OF ANY OTHER VICTIM(S)/ Ex SECURITY GROUP/S – YES – NO

If YES – Name of Group/s Ex-Security Organisations: _____