**APPLICATION FORM**

**Individual Membership (Ordinary Member)**

|  |  |  |
| --- | --- | --- |
| ***Type of membership applied for (please tick the box)*** | | |
| Individual Membership (ordinary members) - (I) Kshs 500 (one-off fee); (II)Annual subscription - Kshs. 2,000; | | |
| **Organisational Information** | | |
| Name: | | |
| Nationality: | | |
| ID/ Passport No: | | |
| Type of organisation: (briefly describe whether State actor, Non-state actor, individual or other) | | |
| Area/Counties of Operation: | | |
| I have attached my CV through [earlychildhoodnetwork2016@gmail.com](mailto:earlychildhoodnetwork2016@gmail.com):Yes NO | | |
| Postal Address: | | |
| Telephone: | Social Media handle(s): | |
| E-mail: | Website: | |
| **Specific Activities/Programs (tick one or more)** | | |
| 1. Advocacy | |  |
| 1. Health | |  |
| 1. Nutrition | |  |
| 1. Opportunities for early learning | |  |
| 1. Parent engagement/responsive caregiving | |  |
| 1. Safety and Security (Child Protection) | |  |
| 1. Other? | |  |
| **Authorization** (to be completed by the duly authorized Head of organization/institution, if applicable) | | |
| On behalf of (name)\_\_\_\_\_\_\_\_\_\_\_, I hereby confirm that the information contained in this application is correct and confirm our application for ECDNeK membership, (name of organization) shares and supports the objectives of ECDNeK. | | |
| Name: | | |
| Title/Position: | | |
| Signature & stamp: Place and Date: | | |
| **FOR OFFICIAL USE ONLY**  Checked by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Approved: □ Declined: □    **Approved by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    If application declined reason for decline. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |