Vancouver West Aikikai Membership Form

Name:

_____

Birth Date: (Month Day Year)

_____

Address:

_____

Home Phone:

_____

_____

Other Phone:

_____

email address:

_____

Emergency Contact Name:

_____

Emergency Contact Phone:

_____

Doctor's Name:

_____

Doctor's Phone:

_____

Current Rank: _____

Date Received: _____

Aikido Start Date:_____

Current Date:_____

Previous Dojo(s) and Sensei(s):_____

_____

_____

Describe any physical or medical condition (including medications) that could affect your ability to practise Aikido:

_____

_____

_____

SUBMIT