



PO Box 6066
Carletonville 2500
South Africa

www.jsc.co.za

Johannesburg Skydiving Club

MEMBERSHIP APPLICATION FORM

Fax completed form **plus** proof of payment to 086 599 2598,
or email hani@jsc.co.za, or hand in at Manifest

Please tick relevant box

<input type="checkbox"/>	New Application for Full Membership	<input type="checkbox"/>	Renewal of Membership
<input type="checkbox"/>	New Application for Temporary / Visitor's Membership		

Surname:	Nick Name:			
First Names:				
Postal Address:				Code:
Residential Address:				Code:
Identity Number:				
Contact Details:	Cellular:			
	Home:		Work:	
	E-mail:			
Occupation:				
Medical Details:	Name of Medical Aid:			
	Medical Aid Membership No.:			
	Medical Aid Contact No.:			
Next of Kin: (Non skydiver)	Name:			
	Relationship:			
	Contact Number(s):			
Residential Address (Next of Kin)				Code:
Reserve Pack Date		Weight		Canopy size
PASA No.:		Time in Sport		No. of Jumps
Existing Licence No's:	A	B	C	D
Current Ratings Held:				



NEW APPLICATIONS

I, the undersigned, whose personal details appear above, hereby apply to the Committee, to become a member of the Johannesburg Skydiving Club.

DETAILS OF MEMBERSHIP WITH OTHER CLUBS

Name of Club(s):	
Period of Membership (approx):	
Reason for leaving said Club:	

INDEMNITY

I, the undersigned, (insert name) do hereby place on record that I will participate in all the activities at Johannesburg Skydiving Club (JSC) at my own risk, and, being aware of all the hazards involved in parachuting, do hereby for myself, my heirs, executors and assigns, indemnify and hold JSC and/or its members harmless against all claims for damages at the instance of myself and/or any member of my family for any loss or injury sustained by me as a result of anything done or omitted by JSC and/or its members and/or its servants and/or its agents up to and including my date of application for membership and/or during the period of my membership.

MEDICAL HISTORY

Do you suffer from, or are you being treated for (tick the appropriate box):

Epilepsy	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Ear problems	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Diabetes	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Dizziness	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Heart condition	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Infections	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Blackouts or dizzy spells	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Eyes:	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
High blood pressure	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Corrective Lenses	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Low blood pressure	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Singe eye/limited vision	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Asthma	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					

Previous fractures:

Legs	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Ankles	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Back	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Wrists	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Shoulders	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

Briefly describe:



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Are you currently under medication?

YES NO

Are you addicted to alcohol or other habit forming drugs?

YES NO

Blood Group: _____ Allergies: _____

CLUB RULES

I hereby undertake to abide by the Club rules, as amended by the Committee from time to time, and acknowledge having received a copy of said rules (available at www.jsc.co.za).

Applicant's Signature: **Date:**

FOR OFFICE USE:

Total payment received:	R	Cash	Credit Card	Date
	JSC	PASA	Aeroclub	Other
Payment allocation:				Other
Received by: (Manifest Officer's Name)				