



Hellenic Organization of Providence & Equality

Breath of H.O.P.E.

Application Form

Full name	_____	Father`s name:	_____
Profession	_____	Age *	_____
Prefecture	_____	District	_____
Address	_____	Post code	_____
Telephone No.	_____	Mobile	_____
Email	_____		
Facebook	_____		
Instagram	_____		

I WISH TO BECOME A MEMBER*

I ONLY WISH TO RECEIVE INFORMATION

ARE YOU A VOLUNTEER ELSEWHERE?
WHERE?

HOBBIES, OTHER ACTIVITIES, INTERESTS OF QUALIFICATIONS WHICH COULD BE USEFUL

HOW COULD YOU HELP US AS A MEMBER?

HOW DID YOU HEAR ABOUT US?
DO YOU HAVE ANY SUGGESTIONS TO HELP US IMPROVE?

* Minimum age 18 years

Thessaloniki, Greece (date) ___/___/2020

Name & signature _____