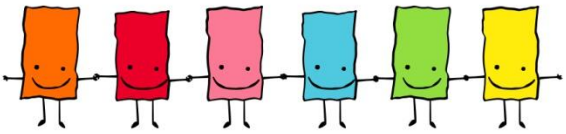

SUKUMANI DREAM

S · T · A · N · D · · T · O · G · E · T · H · E · R

APPLICATION FORM

Recipient Details:

Application for: _____(Child's Name).

Child's DOB: _____

Gender: _____

Diagnosis: _____ GMFCS level: _____

Caregivers name: _____

Contact number: _____

Residential area (or nearest clinic): _____

Therapist Details:

Name of Referring Hospital: _____

Therapists Name: _____

Phone number: _____

Email Address: _____

Standing Frame Details:

Adjustments to foot rest? _____

Foot rest height (number of holes from bottom): _____ Nipple to heel (cms):_____

Buttocks cushion size (small or medium): _____

Extra cushions needed? _____

Date of Application: _____ **Have I taken a photo:** _____

Please email the completed form to: sukumanidream@gmail.com

CONTACT US :
EMAIL : SUKUMANIDREAM@GMAIL.COM
ALISON : 083 497 0610
DEBBIE : 084 504 5475
KABI : 083 629 5454

BANK DETAILS :
BANK : STANDARD BANK
BRANCH : NELSPRUIT : 052852
ACC NO : 132031787
ACC NAME : SUKUMANI DREAM

THANK YOU FOR HELPING OUR CHILDREN TO

S U K U M A

AND MAKING OUR DREAM A REALITY