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## ONE VOICE FOR ONE WELFARE AND ONE HEALTH

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### Network Membership Application Form and Member /Organization Profile

Name of Organization: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Country: \_\_\_\_\_

Telephone (Office): Mobile: \_\_\_\_\_

Email Address: \_\_\_\_\_

Website: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Designation: \_\_\_\_\_

Main objective of the organization: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I confirm that the information given by us is correct to the best of our knowledge

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Please provide a scanned copy of your organization's registration certificate*

