Membership Application Form

RESTAURANTS ASSOCIATION OF IRELAND

Restaurant Details

Contact Name (BLOCK CAPITALS):	Position:

Restaurant/Café/Gastro name:

Full Postal Address:

Tel. No:	Fax No:	Mob No:

Membership Plaque Required: Yes ❏ No ❏	Head Chefs Name:

Restaurant Email:	Personal Email:

Website:	Facebook: www.facebook.com/

Twitter: @	Linkedin (Name of company):

Interested in becoming eligible for Where To Eat One4All Voucher: Yes ❏   No ❏

Interested in taking part in Kids Size Me: Yes ❏   No ❏
Kids Size Me is a joint initiative from the Nutrition & Health Foundation and the RAI on the provision of child size portions of adult meals in restaurants.

If Restaurant is a limited company enter the following:	Company Number:
Name of Company:	Registered Office:

DECLARATION: I HEREBY APPLY FOR FULL MEMBERSHIP OF THE RESTAURANTS ASSOCIATION OF IRELAND FOR THE ABOVE COMPANY. I UNDERTAKE TO ABIDE BY THE ARTICLES OF THE ASSOCIATION AND THE ASSOCIATIONS CHARTER OF GOOD PRACTICE.

Type of Membership: Full Restaurant ❏   Gastro Pub ❏   Coffee Shop ❏   Seasonal Membership ❏   Associate ❏   Additional ❏

Merchant Services provider: None ❏   Elavon ❏   AIB ❏   Other ❏

I wish to make payment by way of: **Please fill direct debit overleaf*	1. Annual Payment: Credit Card ❏ Direct Debit * ❏ Cheque ❏ Bank Transfer ❏ 2. Quarterly: Direct Debit * ❏ 3. Monthly: Direct Debit * ❏

Credit Card Number (Mastercard, Visa and Laser accepted):	☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ LASER MasterCard VISA

Expiry Date:	3 Digit Security Code: ☐☐☐

Name on Card:	Signature:

SEPA Direct Debit Mandate

Unique Mandate Reference (UMR) -   Rest.Assoc

By signing this mandate form, you authorise (A) THE RESTAURANTS ASSOCIATION OF IRELAND LIMITED to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from THE RESTAURANTS ASSOCIATION OF IRELAND LIMITED. As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited.

Please complete all the fields marked*

Field	Value
Debtor Name *	
Debtor Address	
City	
Post Code	
Country	

Debtor account number – IBAN *

Debtor bank identifier code – BIC *

Field	Value
Creditor's name	THE RESTAURANTS ASSOCIATION OF IRELAND LIMITED
Creditor identifier	IE66SDD300611
Creditor address	11 CITY GATE ST AUGUSTINE STREET
City	DUBLIN
Post Code	8
Country	IRELAND

Type of payment *   Recurrent payment ☐   or One-off payment ☐

Date of signature *   D D M M Y Y

Signature(s)

Please sign here *

Note: Your rights regarding the above mandate are explained in a statement that you can obtain from your bank
Please send this mandate to the creditor.