

Application for Membership of Stoma Association

Please accept my application to be enrolled as a member of _____
(Association)

Title: **Surname:** **Given Names:**

Home Address:

Postal Address:

Phone: (Home) **(Mobile)** **(Work)**

Email Address:

Date of Birth: **Medicare No:**

DVA Gold Card Number (if applicable):

** Membership fees and other associated charges incurred by DVA Gold Card Holders eg postage will be paid by Dept of Veterans Affairs*

Pension or Commonwealth Health Card Number: **Exp:**

** A valid Pension or Commonwealth Health card must be presented upon joining, and at each fee renewal to obtain concessional administration fee rate.*

Type of Stoma: **Date of Op:** **Perm: Yes / No, temp_____ months**

Hospital: **Stomal Therapy Nurse:**

If applicable, please provide details of any person who looks after your personal affairs:

Name: **Contact Number:**

Member Declaration

I hereby agree to pay my Association membership fee and any other Association fees (eg postage) for provision of stoma products in terms of the Stoma Appliance Scheme. I agree to abide by the rules of my Association as set out in the Association rules and the Association Information Sheet.

SIGNED (member): _____ **DATE:** _____

ASSOCIATION USE ONLY:

Membership No:
Receipt No:
Entered Computer:

HIC Card Issued:
New member pack issued:
New member order issued: