Dhauwurd-Wurrung Elderly & Community Health Service Inc.

ABN: 98 906 379 843

APPLICATION FOR MEMBERSHIP

Please Note: Membership is to be renewed each year.

Name: ……..

Address: ……..

Town: ……Post Code: ……..

Date of Birth: ……Male □ Female □

Contact Telephone Number: …….. Mobile: ……..

Type of Membership:

□ **Full Membership**

I declare that I am (tick)

[] A person of Aboriginal & Torres Strait Islander descent, **OR**

[] A person recognized as a non Koori partner **AND**

[] I reside within Victoria Western District – Target area of Portland, Heywood & Hamilton Districts.

□ **Associate Membership**

I declare that (tick)

[] I am not an Aboriginal person,

[] I understand that as an Associate Member, I will not have voting rights, will be unable to stand for the committee, nor can I convene or seek to convene a special general meeting.

[] I live within the Victorian Western District – Target area of Portland, Heywood & Hamilton.

I desire to become a member of DHAUWURD-WURRUNG ELDERLY & COMMUNITY HEALTH SERVICE INCORPORATED.
In the event of my admission as a member, I agree to accept and be bound by the rules of the Association and understand that compliance with the rules is the sole responsibility of the applicant.

Signature of Applicant …… Date ____ / ____/ _____

OFFICE USE.

Membership approved by the Board of Directors on ____/____/ _____

Signed by …… (Chairperson)

Member placed on register on ____/____/ _____ and letter of that day sent to the member.

Membership Application fee of $5.00 / Annual Subscription fee of $2.00 received on __/__/__