NSW Stoma Limited

ABN 51 610 218 338

Membership Application

nswstoma LIMITED

Annual Stoma Scheme access fee
(per Government guidelines)

Full Member: **$60.00** Concession Member*: **$50.00**
Associate Member: **$10.00** DVA Gold Card Holders: **Exempt**
Plus **$13 postage/handling** waived for 1st delivery.

**Pensioner and Commonwealth Health Card holders.*

TAX INVOICE

All correspondence to: NSW Stoma Limited
PO Box 164, Camperdown NSW 1450

Unit 5, 7-29 Bridge Road, Stanmore NSW 2048
Tel: 1300 678 669 / (02) 9565 4315
Fax: (02) 9565 4317 Email: info@nswstoma.com.au
Web: www.nswstoma.com.au

***Stoma Scheme Access Fee* for new Members joining NSW Stoma Limited between:**

Membership type	Full	Concession	Associate	DVA		Full	Concession	Associate	DVA
1 July to 30 September	$60	$50	$10	Exempt	1 January to 31 March	$30	$25	$10	Exempt
1 October to 31 December	$50	$40	$10	Exempt	1 April to 30 June	$20	$15	$10	Exempt

I hereby apply to be enrolled as a Member of NSW Stoma Limited

(Tick whichever applies) ☑ Full Member ☐ Concession Member ☐ Associate Member ☐ DVA Gold Card Holder

(Enclose the appropriate fee)

Title: Mr _____ _____
Surname *Given Names*

Residential address: _____

City/Town: _____ Postcode: _____

Postal address *(if different from above)*: _____

City/Town: _____ Postcode: _____ Telephone No: _____

Email: _____ Medicare No: _____

Occupation: _____ Health Card No. *(if applicable)*: _____

Date of birth: _____ /_____ /_____ *(dd/mm/yyyy)* Pension No. *(if applicable)*: _____

Marital status: ☐ Married ☐ Single Veteran Affairs *(if applicable)*: _____

Declaration:

I hereby declare that I reside at the above address AND that I am a permanent resident of Australia.

Signature of new Member

Date: _____ /_____ /_____ *(dd/mm/yyyy)*

Details of Ostomy operation *(Tick applicable box)*

Date of operation: _____ /_____ /_____ *(dd/mm/yyyy)* ☐ Temporary Ostomy ☐ Permanent Ostomy

Type of Ostomy? ☐ Colostomy ☐ Ileostomy ☐ Urostomy ☐ Other? _____

Hospital: _____ Signature of Doctor or Stomal Sister:

Your Doctor or Stomal Sister must sign above unless a separate certificate is attached.

Please accept my payment of $ _____ by: Cheque *(Please select applicable)*

Card type: Only Mastercard or Visa accepted

Cardholder's name *(as appearing on card)*: _____

Card number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry: _____ /_____ *(mm/yy)* **Cardholder's signature:**

NOTE:
1. **Declaration** section above must be signed by the new member.
2. **Pension number** must be provided above otherwise we are unable to register them as a Concession Member and they must pay the Full Member fee.
3. Cheques and Money Orders should be made payable to the NSW Stoma Limited.
4. Membership Application form and payment should be forwarded together with the Australian Government A. B. form to: **NSW Stoma Limited, PO Box 164, Camperdown NSW 1450**

Form ST 01 290318