Ostomy Tasmania Incorporated

MEMBERSHIP APPLICATION

(please tick appropriate boxes)

☐ **$60.00 p.a. Stoma Appliance Scheme (SAS) Access Fee**
☐ **$50.00 p.a. SAS Access Fee (Concession - Centrelink pension or Health Card)**
☐ **$ 10.00 p.a. Associate member** (partner of patient or other interested person)
Postage $15.00 per order **Amount enclosed** _____ **Total** _____

Payment Type ☐ Cheque/Money order ☐ Credit Card ☐ Cash

Credit Card ☐ MasterCard ☐ Visa ☐ Direct banking *(BSB 807 009 a/c no. 5109 4661)*

- ***please include your FULL NAME as reference***

**please note: we are unable to process Savings/Debit cards unless the card holder is present at the office*

Credit Card Number _____ - _____ - _____ - _____ **Expiry Date** ____/____

Card Holder's Name _____ **Card Holders Signature** _____

BLOCK LETTERS PLEASE

FULL NAME (MR / MRS / MS / MISS)_____

ADDRESS _____

POST CODE _____ TELEPHONE (03) _____ (ah) _____ (mob)

DATE OF BIRTH ____/____/____ DATE OF OPERATION____/____/____

MEDICARE NUMBER **(MANDATORY)** _____ Expiry Date _____
(**required for proof of eligibility**)

CONCESSION CARD/ DVA NUMBER _____ Expiry Date _____
(if applicable)

Type of stoma ☐ ILEOSTOMY ☐ COLOSTOMY ☐ UROSTOMY

☐ OTHER (please specify) _____

Is the stoma likely to be ☐ PERMANENT ☐ TEMPORARY ☐ NOT KNOWN

Reason for surgery _____

Type of Appliances Required _____

_____

_____

Signed _____Date_____

Surname and Signature of Doctor or Stomal Therapy Nurse_____

Please complete and return to: The Secretary, P.O. Box 280, Moonah Tas 7009 (*effective November 2018)*