



MEMBERSHIP APPLICATION

(please tick appropriate boxes)

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| <input type="checkbox"/> \$70.00 p.a. Stoma Appliance Scheme (SAS) Access + Association Fee |
| <input type="checkbox"/> \$60.00 p.a. SAS Access + Assoc. Fee (Concession - Centrelink pension or Health Card) |
| <input type="checkbox"/> \$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 Cash Direct banking (BSB 807 009 a/c no. 5109 4661)

Credit Card (Visa/Mastercard) *please note: we are unable to process Savings/Debit cards unless the card holder is present at the office

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

Card Holder's Name _____ Card Holders Signature _____

BLOCK LETTERS PLEASE

SURNAME _____ GIVEN NAMES _____ TITLE _____

ADDRESS _____ POST CODE _____

EMAIL _____ PH (03) _____ (h) _____ (m)

DATE OF BIRTH ____/____/____ DATE OF OPERATION ____/____/____

MEDICARE NUMBER (MANDATORY) _____ Ref No _____ Expiry Date _____
(required for proof of eligibility)

CONCESSION CARD/ DVA NUMBER _____ Expiry Date _____

Applicant Declaration: By signing this form I consent to the collection, verification, use, retention and disclosure of my personal information including sensitive information, for purposes associated with my participation in the Stoma Appliance Scheme. I agree to pay the annual subscription as prescribed.

Signed _____ Date _____

Type of stoma Ileostomy Colostomy Urostomy Other _____

Is the stoma likely to be Permanent Temporary Not known

Surname and Signature of Doctor or Stomal Therapy Nurse _____