OSTOMY tasmania INCORPORATED

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Membership Application and First Order

(please send both pages single sided)

Title _____ Gender _____ Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Surname _____ Given Names _____

Postal Address _____

_____ Postcode: _____

Telephone _____ Email _____

Date of Surgery _____ Type of Stoma: _____ Hospital _____

MEDICARE NUMBER **(MANDATORY)** _____ Ref No_____ Expiry Date _____

CONCESSION CARD/ DVA NUMBER _____ Expiry Date _____

Person nominated to be contacted on behalf of applicant:

Name _____

Telephone _____ Email _____

☐ *Please indicate if you are a responsible person* signing on behalf of the applicant*

Signature: _____ *Relationship to applicant:* _____

** A **Responsible Person** can be a parent, a child or sibling who is at least 18 years old; a spouse or de facto partner; a relative who is at least 18 years old and a member of the applicant's household; a legally appointed guardian; an enduring power of attorney; or a person with whom the applicant has an intimate personal relationship.*

Privacy Notice: Your personal information is protected by law, including the *Privacy Act 1988* (Cth) and the Australian Privacy Principles. We will only collect personal information that is necessary for us to meet or fulfil our activities to you, including to provide you with ostomy products supported through the Commonwealth Stoma Appliance Scheme. Your personal information may be disclosed to Services Australia, the Department of Health and Aged Care, the Australian Council of Stoma Associations, your Stoma Nurse, your medical practitioner, another Stoma Association, a person authorised by you, or another third party for purposes closely related to the primary purpose for which it has been collected and where you would reasonably expect us to disclose your information. We will not share your information for marketing purposes or with overseas recipients without your consent. If you do not provide your personal information, you will be ineligible to receive support from Ostomy Tasmania. A full copy of our Privacy Policy is available from our website www.ostomytas.com.au or by requesting a copy from our office.

Consent: By signing this form I consent to the collection of my personal information, including sensitive information, for purposes associated with my membership with Ostomy Tasmania and for my participation in the Stoma Appliance Scheme. I give consent to Ostomy Tasmania to share my information with the person nominated as an alternative contact in this application. I understand that I can withdraw this consent at any time by contacting Ostomy Tasmania by phone or email.

I agree to pay the Ostomy Tasmania annual subscription (incorporating the Stoma Appliance Scheme Access Fee) as prescribed and any other costs incurred through my participation in the Commonwealth Stoma Appliance Scheme.

Signature_____ **Date:**_____

Office Use:

SAS ID:	Receipt #	Entered:

Initial Order *(optional use – a separate Ostomy Tasmania order form may also be provided with application or later)*

Delivery Method: ☐ Pick up ☐ Postal Delivery ☐ Deliver to an Alternative Address

Alternative address: _____

	Supplier Item No.	Supplier	Description	Number of Packs
1				
2				
3				
4				
5				
6				

☐ Please register me for the Ostomy Tasmania online ordering portal (available Nov 2025).

Email (to be used as login username): _____
Please write clearly

Payment Information

(PLEASE NOTE: initial order will be held until payment has been received):	*Enter amount $*
Stoma Appliance Scheme Access Fee + Association Fee **$85**	
Stoma Appliance Scheme Access Fee + Assn Fee (Concession – Centrelink or Health Care Card) **$75**	
Associate member (partner of patient or other interested person, STN or Medical professional) $**25**	
Postage, Packaging and Handling - **$15** per order (up to 6kg)	
Donation (amounts over $2 are tax deductible)	
Total due now	

Payment Method

☐ DVA ☐ Cheque/Money Order ☐ Cash

☐ Direct Deposit – BSB **807 009** Account No. **5109 4661** Name of Account: **Ostomy Tasmania Inc**
(please include **YOUR NAME** as reference)

☐ For secure electronic payment (rather than email) we recommend paying via our website (Square or PayPal) at https://ostomytas.com.au/payment-donation/ including Client's Full Name as reference.

☐ Visa/Mastercard (submitted by hard copy only) _____ - _____ - _____ - _____

Expiry Date:____/____ CVV:_____

Cardholder Name: _____Sig: _____

☐ Contact for payment: Name _____ Phone _____