

Please provide name, address and phone number; update other details where necessary.

Name: _____ Entitlement No: _____

Address: _____

Email: _____ Postcode _____

Phone no. _____ Date of Order _____

Medicare No: (11 digits) _____ Ref No _____ Expiry date: _____

Concession Card (if applicable): _____ Expiry date: _____

APPLIANCES/PHARMACEUTICALS ITEM AND CODE NUMBER	QUANTITY	COST (if applicable)
Doctor/STN certificate for extra supplies herewith/already sent?		Yes ☐ No ☐
CASH SALE ITEMS (tape, spray etc)		
POSTAGE & HANDLING (per parcel) (please tick appropriate box)	prepaid ☐ DVA ☐ enclosed ☐	\$ 15.00
MEMBERSHIP FEE \$85 Ordinary, \$75 Concession, \$25 Associate	(due 1 July each year)	
DONATION (Tax deductible over \$2.00)		
TOTAL enclosed ☐ Credit Card ☐		\$
Credit Card ____/____/____/____ Expiry Date ____/____ CVV (on back of card) ____ Name on card _____ Signature _____ Direct Credit details: BSB: 807 009 A/c No.: 5109 4661 A/c Name: Ostomy Tasmania Inc (please include your FULL NAME as a reference)		