



Version: June 2025

Unit 3/228 Taren Point Road  
Caringbah NSW 2229  
P O Box 3068  
Kirrawee NSW 2232  
Tel (02) 9542 1300 | Fax (02) 9542 1400  
newmembers@ostomynsw.org.au

Membership Number (Office Use Only)

## Application for Membership

The information you provide is collected and used by Ostomy NSW Limited only for the purpose of supplying you with products under the Stoma Appliance Scheme and is protected under the provisions of privacy legislation.

Last Name		First Name(s)	
Title		Date of Birth	Gender
Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/>		___ / ___ / ___	M <input type="checkbox"/> F <input type="checkbox"/>
Language other than English			

Home Phone No.	Mobile Phone No.	Work Phone No.

e-mail address used for deliveries		tick if not member's email address <input type="checkbox"/> (Associate member)
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Residential Address			
Unit/St No.	Street	Suburb	Post Code

Address for Delivery of Supplies (if different to Residential Address)			
Unit/St No.	Street	Suburb	Post Code

Add here any special instructions for deliveries

Please attach copies of Medicare Card (11 digits) and (if applicable) Pension Card			
Medicare No. _____	Ref No. _____	Valid to: ____ / ____ / ____	
Concession Pension No. _____		Valid To: ____ / ____ / ____	
Type of Operation			
<input type="checkbox"/> Ileostomy	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Urostomy	<input type="checkbox"/> Other
Date of Operation	Name of Hospital	Name of Stomal Therapy Nurse	

SAS Access Fee Required	<input type="checkbox"/> Full Member \$80	<input type="checkbox"/> Pensioner \$70	<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary
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Payment Method – use caution supplying these details. Our online site is secure: <a href="https://www.ostomynsw.org.au/member_payment_21.php">https://www.ostomynsw.org.au/member_payment_21.php</a>				
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Cheque <input type="checkbox"/>	Money Order <input type="checkbox"/>	Cash <input type="checkbox"/>	EFT <input type="checkbox"/>	Credit Card <input type="checkbox"/>
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Name on Credit Card	Credit Card No	Expiry Date	CVC
	____ / ____ / ____ / ____	____ / ____	____

EFT Payments to:	BSB 112-879 Account No. 456643389 Ostomy NSW Limited (identify your payment with your name)		
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I understand that as an Ostomy NSW Limited (ONL) member, I am entitled to voting rights at the Annual General Meeting of ONL and I am eligible for election as a Director. I agree to be bound by the Constitution of ONL as a non-listed Not-for-profit public company limited by guarantee.			
<input type="checkbox"/> I consent to journals, raffle tickets, various information, and offers to be sent to me &/ or Associate Member.			

Signature		Date	
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