



6/555 Princes Highway
 Kirrawee NSW 2232
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 Kirrawee DC NSW 2232
 Tel (02) 9542 1300
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 info@ostomynsw.org.au
 www.ostomynsw.org.au

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.

Title		Date of Birth		Gender		(Office Use Only) Membership No.	
Mr <input type="checkbox"/> Mrs <input type="checkbox"/>				M <input type="checkbox"/>			
Ms <input type="checkbox"/> Dr <input type="checkbox"/>				F <input type="checkbox"/>			
Last Name				First Name(s)			
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							
Contact Details							
☎ Home Phone No.		📱 Mobile Phone No.		☎ Work Phone No.			
✉ e-mail address (if applicable)							
Working Full Time		Working Part Time		Not Working		Occupation	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
Type of Membership Required		<input type="checkbox"/> Full Member (\$45 p.a.)		<input type="checkbox"/> Concession Pensioner (\$35 p.a.)		<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary
Payment Method							
Cheque <input type="checkbox"/>		Money Order <input type="checkbox"/>		Cash <input type="checkbox"/>		EFT <input type="checkbox"/>	Credit Card <input type="checkbox"/>
Name on Credit Card		Credit Card No				Expiry Date	
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EFT Payments to:		BSB 112-879 Account No. 0456643389 Ostomy NSW Limited (Identify your payment with the words "New Member Fees")					
Please attach copies of Medicare Card and (if applicable) Pension Card							
Medicare No.				Concession Pension No.			
Type of Operation							
<input type="checkbox"/> Ileostomy		<input type="checkbox"/> Colostomy		<input type="checkbox"/> Urostomy		<input type="checkbox"/> Fistula	<input type="checkbox"/> Other
Date of Operation		Name of Hospital			Name of Stomal Therapy Nurse		
<i>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.</i>							
Signature				Date			