APPLICATION FOR MEMBERSHIP OF ALBANY HOSPICE INC.

I, ____
(full name of applicant)

Of ____
(address)

____
(occupation)

____
(email)

____
(telephone)

Apply for membership of Albany Community Hospice (select one):

☐ VOLUNTEER membership $20

☐ INDIVIDUAL membership $50

In the event of my admission as a member I agree to be bound by the Constitution of Albany Community Hospice.

______________________________ ______________________

Signature of Applicant *Date*

Please indicate below the method of payment of membership fees:

☐ In person at the Hospice or

☐ Direct deposit - Direct Deposit can be made to: BSB 086-518 A/c No 541-701-256

Please return completed form to Albany Community Hospice via email at admin@albanyhospice.org.au or by post PO Box 5210, Albany WA 6332 or fax to 08 9892 1163.

For office use only:

Receipt provided: ☐ Receipt Number: ___________________ Date: ___________________________

Letter sent: ☐ Membership Register updated: ☐