



APPLICATION FOR MEMBERSHIP

of Sunshine Coast Community Hospice Ltd ABN: 59 111 950 924 Charity No: CH1684

1. PERSONAL DETAILS

Title: _____ Surname: _____ First Name: _____

Residential Address: _____

Suburb: _____ State: _____ Post Code: _____

Home Phone: _____ Mobile Phone: _____

Email: _____ Work Phone: _____

Date of Birth: _____ Occupation: _____

2. REFERENCES: Please provide references of two Personal Referees

(This is not necessary if previous references have been provided)

Name: _____ Contact No: _____

Name: _____ Contact No: _____

3. Please read and sign below – Terms and Conditions of Membership Declarations:

1. Upon election to become a Member of Sunshine Coast Community Hospice Limited I agree to be bound by the Constitution and By-laws of the Hospice and any amendments made thereto.
2. I agree to allow use of my personal contact details for the purpose of day to day running of the Hospice and acknowledge that the Hospice will only use such details under the provisions of the Privacy Act, 1988.
3. I agree that I will choose to be notified and receive all correspondence and access copies of the Hospice Annual Report via electronic media unless I notify the Hospice in writing that I wish to receive printed copies via the mail.

SIGNATURE OF APPLICANT: _____ DATE: _____

PROPOSER Print Name: _____ PROPOSER Print Name: _____

Signature of PROPOSER (FULL MEMBER) _____ Signature of PROPOSER (FULL MEMBER) _____

OFFICE USE ONLY

Date Received: _____ Joining Fee: _____

Date Approved: _____ Annual Fee: _____

Membership Number: _____ Total Due: _____

Confirmation Letter Sent: _____ Total Paid: _____