ACT AND DISTRICTS STOMA ASSOCIATION

Second Floor, Community Care Building
Cnr. Moore and Alinga Streets, Canberra City
Telephone (02) 5124 4888
GPO Box 1260 Canberra ACT 2601
stoma@actstoma.net.au

MEMBERSHIP APPLICATION

TITLE	SURNAME	GIVEN NAME/S
MR/MRS/MS/DR		
HOME PHONE	MOBILE	EMAIL

RESIDENTIAL ADDRESS	SUBURB	STATE	POSTCODE
POSTAL ADDRESS	SUBURB	STATE	POSTCODE

DATE OF BIRTH	NEXT OF KIN NAME	NEXT OF KIN PHONE
DVA # (IF APPLICABLE) EXPIRY	MEDICARE # EXPIRY	HEALTH CARE CARD # EXPIRY

TYPE OF STOMA	PLEASE INDICATE	DATE OF OPERATION
COL/ ILE/ URO/ OTHER	TEMPORARY/ PERMANENT	
NAME OF SURGEON	NAME OF STOMAL THERAPY NURSE	HOSPITAL

ANNUAL FEES (inclusive of Association and SAS fee)	Yearly: 1 July – 30 June
☐ FULL - $85	☐ CONCESSIONAL - $80 (MUST HOLD HEALTH CARE CARD)
☐ ASSOCIATE - $10	☐ DVA GOLD CARD HOLDER - EXEMPT

PAYMENT METHOD			
☐ CHEQUE	☐ EFT	☐ CASH	CREDIT CARD (VISA/ MASTERCARD)
NAME ON CREDIT CARD		EXPIRY DATE	
CREDIT CARD #		CCV #	

By signing this form I consent to the collection, use, retention and disclosure of my personal information for purposes associated with my participation in the Stoma Appliance Scheme. I also agree to pay the yearly Stoma Access Scheme fee as prescribed and to abide by the Association Rules and Member Code of Conduct. I acknowledge that a full copy of the ACT & Districts Stoma Association Privacy Policy, Rules, and Member Code of Conduct are available by contacting the association.

☐ I HAVE ATTACHED COPIES OF MY MEDICARE, DVA AND ENTITLEMENT CARDS AND MY COMPLETED STOMA APPLIANCE SCHEME APPLICATION FO.

SIGNATURE		DATE	