

MEMBERSHIP FORM



Member Details:

Title: _____ First name: _____ Surname: _____

Address: _____ Postcode: _____

Phone: _____ Mobile: _____ E-mail: _____

Gender: Male Female Date of birth: ___/___/___ Country of birth: _____

Are you Aboriginal or Torres Strait Islander? Yes No

Are you a family Carer? Yes No

Are you currently in the workforce? Full time Part time No

If you are a family Carer, please provide the details of the person you are caring for & answer other questions below:

Title: _____ First name: _____ Surname: _____

Address (if different to above): _____ Postcode: _____

Phone: _____ Mobile: _____ E-mail: _____

Gender: Male Female Date of birth: ___/___/___ Country of birth: _____

Condition of Care Recipient:

Physical disability Intellectual Disability Chronic illness Frail aged Mental illness

Other Option: Specify Condition: _____

Are they Aboriginal or Torres Strait Islander? Yes No

What year did you commence your caring role? _____

What is your relationship to the person you care for? (e.g. I am their wife /son/mother): _____

By signing this form you are agreeing to allow us to store your information in our confidential database, provide this information (without your name, address and contact details) to our funding bodies for statistical and planning purposes, and send you relevant information, including a copy our quarterly Newsletter (4 per year) and invitations to workshops and special member events.

Signed: _____ Date: ___/___/___

*While Carers ACT Membership is **FREE**, we invite you to make a tax deductible donation (\$2 or more) to assist us to continue improving and expanding our services. If you would like to make a donation please fill out the section below.*

Name: _____

Address: _____ Postcode: _____

I wish to donate: \$10 \$20 \$50 Other _____

I have enclosed a cheque/money order for my donation payable to "Carers ACT" **OR**

Please charge to my credit card (min \$10):

Bankcard Visa MasterCard Other _____

Card number: _____ Expiry: ___/___

Name on Credit Card: _____

Signed: _____ Date ___/___/___

Please post completed form to: Carers ACT, Ground Floor, Belconnen Churches Centre, 54 Benjamin Way, Belconnen 2617