Membership Application

nswstoma LIMITED

TAX INVOICE

All correspondence to: NSW Stoma Limited
PO Box 164, Camperdown NSW 1450

Unit 5, 7-29 Bridge Road, Stanmore NSW 2048
Tel: 1300 678 669 / (02) 9565 4315
Fax: (02) 9565 4317
Email: info@nswstoma.org.au
Web: www.nswstoma.org.au
ABN 51 610 218 338

Annual membership Fee and Access Fee to the Stoma Appliance Scheme (SAS)

(per Government guidelines)

Full Member:	**$70***	Concession Member**:	**$60***
Associate Member:	**$10**	DVA Gold Card Holders:	**Exempt**

Postage Fees waived for first order

* *Total annual fees include SAS Access fee ($60 full membership, $50 Concession) plus $10 NSW Stoma Ltd fee*

** *Pensioner Card holders*

I hereby apply for membership with NSW Stoma Limited

(Tick whichever applies) ☐ Full Member ☐ Concession Member ☐ Associate Member ☐ DVA Gold Card Holder

_____ _____
Surname *Given Names*

Residential address: _____

City/Town: _____ Postcode: _____

Postal address *(if different from above)*: _____

City/Town: _____ Postcode: _____

Email *(for all member notifications)*: _____

Phone: (h): _____ (m): _____ Medicare No: _____

Pension CRN *(if applicable copy of card must be received with application)*: _____

Date of birth: _____ / _____ / _____ *(dd/mm/yyyy)* Veteran Affairs No. *(if applicable)*: _____

Other Contact: _____

Relationship to member: _____ Phone: _____

Declaration

I hereby declare that I reside at the above address AND that I am a permanent resident of Australia.

Signature of new Member

Date: _____ / _____ / _____ *(dd/mm/yyyy)*

Details of Ostomy operation *(Tick applicable box)*

Date of operation: _____ / _____ / _____ *(dd/mm/yyyy)* ☐ Temporary Ostomy ☐ Permanent Ostomy

Type of Ostomy: ☐ Colostomy ☐ Ileostomy ☐ Urostomy ☐ Other: _____

Hospital: _____ Name of Doctor or Stomal Therapy Nurse: _____

This form must be accompanied by a completed Stoma Appliance Scheme Application form from your GP or Stomal Therapy Nurse.

PAYMENT

Membership Fee: $_____

☐ **Direct Deposit**: **Account Name:** NSW Stoma Ltd **BSB:** 012-205 **Acc No:** 299264819 **Ref:** Your Name & Member No.

☐ **Cheque**: Must be addressed to: NSW Stoma Ltd, PO Box 164, Camperdown NSW 1450

☐ **Mastercard** or **Visa**: Cardholder's name (as appearing on card): _____

Card number: Expiry (mm/yy):

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐ / ☐☐

Cardholder's Signature

NOTE: 1. **Declaration** section above must be signed by the new member.
2. **Pension number** must be provided above otherwise we are unable to register them as a Concession Member and they must pay the Full Member fee.
3. Cheques and Money Orders should be made payable to the NSW Stoma Limited.
4. Membership Application form and payment should be forwarded together with the Australian Government Stoma Appliance Scheme Application form to: NSW Stoma Limited, PO BOX 164, Camperdown or emailed to: info@nswstoma.org.au or faxed to: 02 9565 4317

Form ST 01 140520