## MEMBERSHIP APPLICATION & FIRST ORDER FORM



Unit 5, 7-29 Bridge Road, Stanmore NSW 2048 1300 678 669 / 02 9565 4315 Fax: 02 9565 4317 www.nswstoma.org.au

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First Name:		Last Na	me:				
Delivery Address:	<del></del>		· · · · · · · · · · · · · · · · · · ·	<del> </del>			
Email (for member notific	cations):						
Phone (M):		_ (H):					
Medicare No. (copy requi	red)*:		Ref. No.:	Exp:	/		
Pension/Concession CRN	(copy required)*:			Exp:	/		
Date of Birth: /_	/	Veteran Affairs N	o. (if applicable)*:	:			
Please indicate if you	are a <b>responsible</b>	person* signing	on behalf of the a	pplicant.			
Name:	Relation	ship to Applicant	:	Phone:			
* A responsible person of a relative who is at least 18 enduring power of attorned * Copies of Medicare, DV/member fee applies. If end	Byears old and a mey; or a person with	nember of the app on whom the applic esssion Card (if app	licant's household ant has an intimat blicable) must be p	; a legally appo e personal rela provided. Witho	ointed guardian; an itionship.		
My ostomy is a Tem		y ostomy	Permanent os	Permanent ostomy			
Type: Colostomy	lleostomy	Urostomy	Other:				
Date of Operation:	_//_	Hospital: _	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·		
This form must be accompani							
APPLICANT DECLARATIO	N AND CONSENT						
Privacy Notice: Your person Australian Privacy Principles. our duties to you, including property our personal information material of Stoma Association by you, or another third part would reasonably expect us to overseas recipients without your support from NSW Stoma Ltwebsite (www.nswstoma.org	This means we will providing your ostor ay be disclosed to Sas, your stoma nursey for purposes related to disclose your inforwour consent. If you d (NSL). A full copywau) or by requesting to the consent.	only collect person my products through services Australia, the e or medical practified to the primary rmation. We will now do not provide you of our privacy polic g a copy from NSL.	ial information tha h the Commonwer ne Department of I tioner, another stor ourpose for which t share your inform or personal informa y is available upon	It is necessary for alth Stoma Apple Health and Ageoma association, it has been colleation for marke ation, you will be request and is a	or us to meet or fulfi iance Scheme (SAS) d Care, the Australiar person(s) authorised ected and where you ting purposes or with e ineligible to receive also accessible on our		
<b>Consent:</b> By signing this for purposes associated with my to NSL to share my informatican withdraw this consent at	membership with Non with the person(s	ISL and for my part s) nominated as an	icipation in the Stor alternative contact	ma Appliance So	cheme. I give consen		
I acknowledge that a full cop Charter of Service, and Meml Association Rules and Memb incurred through my particip	per Code of Conduct er Code of Conduct,	is available on the N , and to pay the NS	ISL website or by co L annual subscripti	ontacting NSL. I	agree to abide by the		

Full Name Signature Date



## **Supply Order Form**

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

(per Government guidelines)

Full Member: \$80 Concession Member\*: \$70

Associate Member: \$10 DVA Gold Card Holder: Exempt

\* Pension and Concession Card holders

APPLIANCE/ITEM		BRAND	CODE NO. ON BOX	QTY. IN PACK	NO. C PACK	)F (S (QTY	TOTAL  (QTY. IN PACK × NO.  OF PACKS)	
<b>DELIVERY METHOD:</b> Pic	k Up	Postal Delive	ry De	eliver to an Alte	ernative	Address	;	
Alternative Address:					_			
<b>DUE:</b> POSTAGE waive		ed for first order; standard for one month supply i			17	\$		
ANNUAL MEMBERSHIP FE	ides set-up fee; expires 30 <sup>th</sup> June regardless of date joined				\$			
DONATION	dona	nations of \$2 or more are tax deductible						
TOTAL						\$ <b>\$</b>		
PAYMENT:					•			
Direct Deposit: <b>Acc. Name:</b> NS Cheque — Please address to: <b>N</b>			_	_		₁e & Mer	nber No.	
Mastercard or Visa: Cardholder			·	_				
Card Number:				Expiry:				
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**THANK YOU:** This form and payment should be forwarded together with your completed Department of Health and Aged Care Stoma Appliance Scheme Application Form to: **NSW Stoma Limited, PO BOX 164, Camperdown** or by email (**info@nswstoma.org.au**) or fax to **02 9565 4317**.