

# 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](mailto:info@nswstoma.org.au)

Web: [www.nswstoma.org.au](http://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: **\$80**

Concession Member\*: **\$70\***

Associate Member: **\$10**

DVA Gold Card Holders: **Exempt**

Postage Fees waived for first order

\*Pensioner Card holders

Your first payment includes setup costs and all memberships expire on 30th June each year regardless of the date you join.

#### 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): \_\_\_\_\_ Medicare No (copy of Medicare card is required): \_\_\_\_\_

(m): \_\_\_\_\_ Pension CRN (copy of card is required): \_\_\_\_\_

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):

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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](mailto:info@nswstoma.org.au) or faxed to: 02 9565 4317