

Spinal Muscular Atrophy Association of Australia Inc.

MEMBERSHIP APPLICATION FORM



I would like to become a member of the SMAAA.

Name: _____

Address Details: _____

Postcode: _____

Phone: _____ Mobile: _____

Email: _____

In the event of my admission as a member, I agree to be bound by the rules of the Association for the time being in force.

Signed: _____ Date: _____

I am a:

- | | |
|--------------------------------|---|
| <input type="radio"/> Sufferer | <input type="radio"/> Extended family and/or friend |
| <input type="radio"/> Parent | <input type="radio"/> Organisation and/or Self help group |
| <input type="radio"/> Sibling | |

Payment Details

- Payment enclosed:
 - \$10 for low income individuals and/or families (upon the presentation of a health care or pension card) ****please attach a copy****
 - \$20 for non low income individuals and/or families
 - \$30 for organisations and/or self help groups

Please Note: An annual renewal fee of \$10 is payable on 1 July

Send to: Spinal Muscular Atrophy Association of Australia Inc.

ABN: 82885991569 No: 0047660D

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