Arthritis AUSTRALIAN CAPITAL TERRITORY Including Osteoporosis ACT
170 Haydon Drive, Bruce ACT 2617 or SHOUT OFFICES, Collet Place, Pearce ACT 2607 - PO Box 908, Belconnen ACT 2617
P: 1800 011 041 F: (02) 6251 2066 E: info@arthritisact.org.au

NEW MEMBER APPLICATION

Title:	First name:	Last name:	
Address:			Suburb/Town:
State/Territory:	Postcode:	Date of Birth: : ___ ___ / ___ ___ / ___ ___	
Phone (h):	Phone (w):	Mobile:	
Email address:		Confirm email address:	
Pension Number:			

ADDITIONAL FAMILY MEMBER - ONE

Title:	First name:	Last name:	Relationship:
Date of Birth: : ___ ___ / ___ ___ / ___ ___		Email address:	

ADDITIONAL FAMILY MEMBER - TWO

Title:	First name:	Last name:	Relationship:
Date of Birth: : ___ ___ / ___ ___ / ___ ___		Email address:	

WHICH OF THE FOLLOWING DO YOU OR YOUR FAMILY MEMBERS HAVE? (Please tick the box/es)

☐ Osteo**arthritis**	☐ Rheumatoid Arthritis	☐ Ankylosing Spondylitis	☐ SLE (Lupus)
☐ Juvenile Arthritis (JA)	☐ Gout	☐ Fibromyalgia	☐ Sjogren's Syndrome
☐ Osteo**porosis**	☐ Psoriatic Arthritis	☐ Other type of arthritis	☐ Not sure

MEMBERSHIP SUBSCRIPTIONS (NB Pensioners = Centrelink/Veteran Affairs pension only)

Membership (includes Warm Water Exercise)					
Individual ($67)					$
Pensioner/Full-time Student ($49)					$
Family ($103)					$
Pensioner Family ($77)					$
Health Professional/Organisation ($45)	$				
Corporate ($125)	$	**Donation** (over $2 is tax deductible)			$
Warm Water Exercise Tickets – Member					
Single Tickets __ @ $5.60	$	20 Tickets ___ @105	$	40 Tickets___ @ $200	$
Warm Water Exercise Tickets – Family Member One					
Single Tickets __ @ $5.60	$	20 Tickets ___ @105	$	40 Tickets___ @ $200	$
Warm Water Exercise Tickets – Family Member Two					
Single Tickets __ @ $5.60	$	20 Tickets ___ @105	$	40 Tickets___ @ $200	$
Total Amount Enclosed (Membership + Donation + Warm Water Exercise Tickets)					**$**

ADDITIONAL INFORMATION FOR WARM WATER EXERCISE

Before commencing the warm water exercise program each person must provide a Medical Clearance form completed by their doctor. Medical Clearance forms are to be returned by email, fax, post or in person to one of the addresses shown at the top of the form.

PAYMENT INFORMATION (Please tick the box)

☐ Cash	☐ Cheque[1]	☐ Money Order[1]	☐ Mastercard	☐ Visa

Card Number: ___ ___ ___ ___ | ___ ___ ___ ___ |__ __ __ __ | __ __ ___ ___	CCV Number[2] : ___ ___ ___
Card Holder's Name:	Expiry Date (mm/yy): ___ ___ / ___ ___
Signature of Applicant::	Date: ___ ___ / ___ ___ / ___ ___ ___ ___

[1] Payable to Arthritis ACT

[2] The CCV is mandatory; this is the last 3 digits on the back of the card.

If you do not wish to receive information about musculoskeletal conditions, our newsletter or donation requests from Arthritis and Osteoporosis ACT please tick this box ☐