

**MOTOR NEURONE DISEASE ASSOCIATION OF WESTERN AUSTRALIA Inc**

**MEMBERSHIP APPLICATION/RENEWAL FORM**

|                        |  |
|------------------------|--|
| <i>Office Use Only</i> |  |
| Entered Date           |  |
| Entered By             |  |

Please tick  **New Member**     **Renewal of Membership**

|   |  |
|---|--|
| Title: Ms Mrs Mr Dr                       |  |
| Given Name                                | Surname  |
| Postal Address                            |  |
| Postcode                                  |  |
| Email                                     |  |
| Phone (M)                                 |  |
| Phone (W)                                 | Phone (H)  |
| Please send my copy of the Newsletter by: | <input type="checkbox"/> Email <input type="checkbox"/> Hard copy posted |

| MEMBERSHIP CATEGORIES  | ANNUAL FEE | \$ |
|--|------------|----|
| <b>CARE MEMBER</b> – Carer of person diagnosed with MND                                  | \$10.00    |    |
| <b>MEMBER</b> – Supporter  | \$20.00    |    |
| <b>ASSOCIATE MEMBER</b> – student, or non-Western Australian residents                   | \$10.00    |    |
| <b>CORPORATE MEMBER</b> – A corporate entity or Government Agency                        | \$100.00   |    |
| I also enclose a donation to the Association (All donations over \$2 are tax deductible) |            |    |
| <b>Total Payment</b>   | <b>\$</b>  |    |

|  |                               |                                     |                                       |
|--|-------------------------------|-------------------------------------|---------------------------------------|
| <b>PAYMENT DETAILS</b>                           |                               |                                     |                                       |
| <input type="checkbox"/> Cash/Cheque/Money Order | <input type="checkbox"/> VISA | <input type="checkbox"/> MasterCard | <input type="checkbox"/> Direct Debit |

Credit Card No.

-     -     -          3 digit ID number

|                     |                        |
|---------------------|------------------------|
| Name of Cardholder: | Card Expiry Date:    / |
| Signature:          | Date:                  |

**YES!** I would like to make a regular giving donation. If you ticked yes, the Association will contact you to arrange this.

*MNDAWA from time to time may publish lists of members, or in the interest of research and fundraising, makes the membership list available to approved organisations. Your consent will be assumed unless you request removal of your name from any published list.*

|  |                          |
|--|--------------------------|
| I wish to have my name removed from any published list of Members (please tick <input checked="" type="checkbox"/> ) | <input type="checkbox"/> |
|--|--------------------------|

**Members Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**On Behalf of Member:** \_\_\_\_\_

**Please email your application to [website@mndawa.asn.au](mailto:website@mndawa.asn.au) or post it to us at 1/184 Raleigh Street, Carlisle WA 6101.**

**OFFICE USE ONLY**

|                |                      |
|----------------|----------------------|
| Membership Exp | <input type="text"/> |
|----------------|----------------------|

**APPLICATION NOMINATED BY CURRENT MEMBER – For New Applicants Only**

**Members Name:** \_\_\_\_\_

**Members Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_