

# MEMBERSHIP APPLICATION / RENEWAL



Name of Donor: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Mobile: \_\_\_\_\_  
 E-mail: \_\_\_\_\_

Donor Gift of \$\_\_\_\_\_ accompanies this application for Membership  
 Please tick category: \*GST Inclusive

| GENERAL MEMBERSHIP                                 |                                   | OSTOMY MEMBERSHIP                       |                                  |
|--|-----------------------------------|---|----------------------------------|
| *Individual  | \$ 25.00 <input type="checkbox"/> | <i>Includes CCNT General Membership</i> |                                  |
| *Family  | \$ 35.00 <input type="checkbox"/> | * Individual                            | \$50.00 <input type="checkbox"/> |
| *Corporate<br>(Two nominees)                       | \$100.00 <input type="checkbox"/> | * Pensioner                             | \$45.00 <input type="checkbox"/> |
| *Register Volunteer                                | \$ 15.00 <input type="checkbox"/> | <i>Type of Surgery:</i>                 |                                  |
| If Corporate membership, enter two nominees below: |                                   | Ileostomy                               | <input type="checkbox"/>         |
| 1.....   |                                   | Colostomy                               | <input type="checkbox"/>         |
| 2.....   |                                   | Urostomy                                | <input type="checkbox"/>         |
|  |                                   | Medicare No:                            | .....                            |
|  |                                   | Vet Affairs:                            | .....                            |
|  |                                   | Date of Birth:                          | .....                            |

Signature ..... Date .....

Membership / donation Amount: \$ \_\_\_\_\_

Payment method: Cheque  Money order  Credit Card

Please debit my credit card: *Debit will appear on your statement as The Cancer Council NT*

MasterCard  Bankcard  Visa

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|

Expiry date: \_\_\_\_ / \_\_\_\_

Name on Credit Card \_\_\_\_\_

Signature:

\_\_\_\_\_

Please send Membership form to:  
 PO Box 42719 Casuarina NT 0811  
 Fax 08 8927 4990  
 admin@cancernt.org.au

For Office use only: Date received \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Amount: \$ \_\_\_\_\_ Recorded Receipt # \_\_\_\_\_  
 Recorded by: \_\_\_\_\_