APPLICATION FOR MEMBERSHIP OF ALBANY HOSPICE INC.

I, _____
(full name of applicant)

Of _____
(address)

_____
(occupation)

_____
(email)

_____
(telephone)

Apply for membership of Albany Community Hospice (select one):

☐ VOLUNTEER membership $20

☐ INDIVIDUAL membership $50

In the event of my admission as a member I agree to be bound by the Constitution of Albany Community Hospice.

_____ _____
Signature of Applicant *Date*

Please indicate below the method of payment of membership fees:

☐ In person at the Hospice or

☐ Direct deposit - Direct Deposit can be made to: BSB 086-518 A/c No 541-701-256

Please return completed form to Albany Community Hospice via email at admin@albanyhospice.org.au or by post PO Box 5210, Albany WA 6332

For office use only:

Receipt provided: ☐ Receipt Number: _____ Date: _____

Letter sent: ☐ Membership Register updated: ☐

Albany Community Hospice
PO Box 5210, Albany 6332
Telephone: 08 9892 2456 Email: admin@albanyhospice.org.au www.albanyhospice.org.au