# MEMBERSHIP APPLICATION

The following terms apply:

* Members must be 18 years of age or older;
* Memberships are due for renewal on the 1st of September each year;

I/we wish to apply for membership of ARC Disability Services Inc.

|  |  |  |  |
| --- | --- | --- | --- |
| **SURNAME** |       | **GIVEN NAMES** |       |
| **POSTAL ADDRESS** |       |
|       | **POST CODE** |       |
| **EMAIL** |       |
| **MOBILE NO.** |       | **HOME PHONE NO.** |       |

|  |
| --- |
| [ ]  Cash/Eftpos payment $5.00 **per person**I have enclosed the membership fees with this form |

OR

|  |
| --- |
| [ ]  Electronic Funds Transfer $5.00 **per person*****BSB:*** 064804 ***ACCOUNT NUMBER:*** 916274 ***REFERENCE*** # Your name |

**SIGNED by the APPLICANT 1:**

|  |  |
| --- | --- |
| **FULL NAME** |       |
| **SIGNATURE** |       | **DATE** |       |

**SIGNED by the ADDITIONAL APPLICANT:**

|  |  |
| --- | --- |
| **FULL NAME** |       |
| **SIGNATURE** |       | **DATE** |       |

**SIGNED by the ADDITIONAL APPLICANT:**

|  |  |
| --- | --- |
| **FULL NAME** |       |
| **SIGNATURE** |       | **DATE** |       |

**Please return form to:**

ARC Disability Services Inc

PO Box 942N

North Cairns Qld, 4870

## *OFFICE USE ONLY*

[ ]  $5.00 enclosed (cash/eftpos)

 Receipt number..........................

OR

[ ]  $5.00 electronic funds transfer received

 Receipt number..........................

**PROPOSED BY:**

|  |  |
| --- | --- |
| **FULL NAME** |       |
| **SIGNATURE** |       | **DATE** |       |

**SECONDED BY:**

|  |  |
| --- | --- |
| **FULL NAME** |       |
| **SIGNATURE** |       | **DATE** |       |

(*NB:* *Proposer and seconder must be current members of ARC)*

|  |  |
| --- | --- |
| **DATE ACCEPTED AT BOARD MEETING** |       |
| **DATE RECORDED ON MEMBERSHIP REGISTER** |       |

**PROCESSED BY:**

|  |  |  |  |
| --- | --- | --- | --- |
| **FULL NAME** |       | **POSITION** |       |
| **SIGNATURE** |       | **DATE** |       |