# 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** |  |