



MEMBERSHIP APPLICATION FORM

for the year to 30th June 2011

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AUSTRALIAN INFANT CHILD
ADOLESCENT & FAMILY MENTAL
HEALTH ASSOCIATION LTD
ABN 870 934 790 22



All information supplied on this form will be kept confidential. The Association may from time to time release the name and contact phone number of members to people for professional purposes only. If you would prefer that none of your contact information is released, please indicate this below.

I do not consent to the release of any of my contact details for any purpose.

CONTACT DETAILS

Please complete this section using your preferred contact details.

NAME: (please include title) _____

POSITION: _____

ORGANISATION: _____

ADDRESS: _____

STATE: _____ POSTCODE: _____ COUNTRY: _____

TELEPHONE: _____ FACSIMILIE: _____

EMAIL ADDRESS: _____

EMAIL LIST/S I am a member of an AICAFMHA email list Please send me an email invitation to join the AICAFMHA News list.

PAYMENT DETAILS

Enclosed is my: cheque (payable to AICAFMHA)
 money order

OR

Please charge my credit card:

- Visa
 Mastercard

Membership Rate: (rates include GST)

- Consumer/Carer/Youth/Student **\$22.00**
 Professional **\$49.50**
 Organisation **\$99.00**

Credit card charge amount: \$ _____

Full name of cardholder: _____

Cardnumber: _____ - _____ - _____ - _____

Valid from: _____ / _____ Expiry: _____ / _____

Signature: _____