



# MEMBERSHIP APPLICATION FORM

for the year to 30th June 2012

AICAFMHA  
PO Box 387  
Stepney SA 5069

ph: 08 8367 0888  
fax: 08 8367 0999  
email: secretary@aicafmha.net.au  
website: http://www.aicafmha.net.au

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: \_\_\_\_\_