



Wound Care Association of NSW Inc

PATRON: Bryce Courtenay AM

Membership Application/Renewal Form & Tax Invoice

WEBSITE: www.ciap.health.nsw.gov.au/wcansw EMAIL: wcansw@lists.health.nsw.gov.au

ABN: 24129141624

04/05

Name: _____ Profession: Nursing Medical Allied Trade

Address: _____

Postcode: _____ Phone (H/W): _____

Email: _____ Place of Employment: _____

TYPE OF MEMBERSHIP: (Refer to "Rules" for clarification)			NEW	RENEWAL
<i>Full</i> (Individual Professionals)	\$60 pa	(GST included = \$0)	[]	[]
<i>Full</i> (2x consecutive years)	\$100	(GST included = \$0)	[]	[]
<i>Corporate</i> (Trade)	\$120 pa	(GST included = \$0)	[]	[]
<i>Corporate</i> (2 x consec years)	\$200	(GST included = \$0)	[]	[]
<i>Associate</i> (Others)	\$60 pa	(GST included = \$0)	[]	[]
<i>Associate</i> (2 x consec years)	\$100	(GST included = \$0)	[]	[]

Membership Package is in CD format. If you require a hard copy tick here []

I AGREE TO ACCEPT THE "RULES" & "BY-LAWS" OF THE ASSOCIATION:

Signature: _____ DATE _____

Please send completed application form and payment to:
The Membership Secretary WCANSW
PO Box 402 Connells Point Road South Hurstville NSW 2221

CURRENT TO: _____

RECEIPT NO: _____

This tear-off portion will be destroyed following payment.

PAYMENT by: Cheque payable to WCANSW Visa Card Mastercard (please circle)

Card No: _____

Expiry Date: _____ Amount: \$ _____

Name on Card: _____ Signature: _____