



# Ostomy Tasmania Incorporated

## MEMBERSHIP APPLICATION

(please tick appropriate boxes)

<input type="checkbox"/> \$70.00 p.a. Stoma Appliance Scheme (SAS) Access + Association Fee
<input type="checkbox"/> \$60.00 p.a. SAS Access + Assoc. Fee (Concession - Centrelink pension or Health Card)
<input type="checkbox"/> \$ 10.00 p.a. Associate member (partner of patient or other interested person)
Postage \$15.00 per order      Amount enclosed _____      Total _____

Payment Type  Cheque/Money order       Credit Card       Cash

Credit Card  MasterCard     Visa       Direct banking (BSB 807 009 a/c no. 5109 4661)  
 • please include your FULL NAME as reference

\*please note: we are unable to process Savings/Debit cards unless the card holder is present at the office

Credit Card Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Expiry Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Card Holder's Name \_\_\_\_\_      Card Holders Signature \_\_\_\_\_

BLOCK LETTERS PLEASE

FULL NAME (MR / MRS / MS / MISS) \_\_\_\_\_

ADDRESS \_\_\_\_\_

POST CODE \_\_\_\_\_ TELEPHONE (03) \_\_\_\_\_ (ah) \_\_\_\_\_ (mob) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_      DATE OF OPERATION \_\_\_\_/\_\_\_\_/\_\_\_\_

MEDICARE NUMBER (MANDATORY) \_\_\_\_\_ Expiry Date \_\_\_\_\_  
(required for proof of eligibility)

CONCESSION CARD/ DVA NUMBER \_\_\_\_\_ Expiry Date \_\_\_\_\_  
(if applicable)

Type of stoma       ILEOSTOMY       COLOSTOMY       UROSTOMY

OTHER (please specify) \_\_\_\_\_

Is the stoma likely to be       PERMANENT       TEMPORARY       NOT KNOWN

Reason for surgery \_\_\_\_\_

Type of Appliances Required \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Surname and Signature of Doctor or Stomal Therapy Nurse \_\_\_\_\_