



Application for Membership

I hereby apply for membership of Ranges Community Health and consent to such membership and agree to the Constitution and to the requirement to guarantee Ranges Community Health to the extent set out in the Constitution.

- Membership of the Company is for the period from the entry of their name in the register until 30 June in any year.
- Members must renew their membership during the months of May and June but prior to 30 June.
- No person may be admitted as a Member after 30 June until the Register reopens on the day after the next Annual General Meeting

I confirm that I am over 18 years of age.

And I:

- Live, work or am enrolled as a student at an educational institution in the Shire of Yarra Ranges; or
- Volunteer with the Service;
- Am a client of the Service; or
- Am a(specify relationship)

I am applying as a new member of Ranges Community Health

First Name			
Last Name			
Street Address			
Suburb			Post Code
Telephone	Home:	Mobile:	Work:
Email			

Please circle your preferred form of communication: Mail Email

Applicant Signature _____ **Date** ___/___/___

Membership entitles you to:

- Nominate to become a Board Director
- Attend members meetings
- Vote in Board elections
- Receive a copy of our Annual Report and Community Newsletters
- Receive updates about activities, new services and special events at Ranges Community Health

Please complete the next section 'HAVE YOUR SAY' and return together with this form



HAVE YOUR SAY

There are key times at Ranges Community Health when we ask people in our community to share their opinions and help make decisions about our service. To enable us to target people appropriately we need a bit more information about you.

If you would like to receive invitations to participate in events, discussions, surveys and workshops relevant to you, please enter these details below:

Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Age: <input type="checkbox"/>	Do you have a Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a Long Term Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a Carer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you Aboriginal or Torres Straight Islander: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Country of Birth:	Language spoken at home:	
How old are your children? (tick all which apply) <input type="checkbox"/> 0-6 <input type="checkbox"/> 7-12 <input type="checkbox"/> 13-17 <input type="checkbox"/> 18-25		
Have you used RCH Services in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Availability: <input type="checkbox"/> Anytime <input type="checkbox"/> Weekdays 10-2pm <input type="checkbox"/> Evenings after 5pm		

I do not wish to participate any events, discussions, surveys and/or workshops

Please send completed forms to: Ranges Community Health, 17 Clarke St, Lilydale, 3140 or fax: 9739 4689 or email: referral@rangeschs.org.au

Business Use Only:

Date of receipt:

Considered by Board:

Decision of Board:

Entry in Register:

Letter sent: