

# MEMBERSHIP APPLICATION / RENEWAL 2009



Name of Donor: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Mobile: \_\_\_\_\_  
 E-mail: \_\_\_\_\_

Donor Gift of \$\_\_\_\_\_ accompanies this application for Membership  
 Please tick category: \*GST Inclusive

GENERAL MEMBERSHIP		OSTOMY MEMBERSHIP	
*Individual	\$ 25.00 <input type="checkbox"/>	<i>Includes CCNT General Membership</i>	
*Family	\$ 35.00 <input type="checkbox"/>	* Individual	\$50.00 <input type="checkbox"/>
*Corporate (Two nominees)	\$100.00 <input type="checkbox"/>	* Pensioner	\$45.00 <input type="checkbox"/>
*Register Volunteer	\$ 15.00 <input type="checkbox"/>	<i>Type of Surgery:</i>	
If Corporate membership, enter two nominees below:		Ileostomy	<input type="checkbox"/>
1.....		Colostomy	<input type="checkbox"/>
2.....		Urostomy	<input type="checkbox"/>
		Medicare No:	.....
		Vet Affairs:	.....
		Date of Birth:	.....

Signature ..... Date .....

Membership / donation Amount: \$ \_\_\_\_\_

Payment method: Cheque  Money order  Credit Card

Please debit my credit card: *Debit will appear on your statement as The Cancer Council NT*

MasterCard  Bankcard  Visa

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Expiry date: \_\_\_\_ / \_\_\_\_

Name on Credit Card \_\_\_\_\_

Signature:

\_\_\_\_\_

Please send Membership form to:  
 PO Box 42719 Casuarina NT 0811  
 Fax 08 8927 4990  
 admin@cancernt.org.au

For Office use only: Date received \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Amount: \$\_\_\_\_\_ Recorded Receipt # \_\_\_\_\_  
 Date registered \_\_\_\_/\_\_\_\_/\_\_\_\_ Authorisation # \_\_\_\_\_  
 Recorded by: \_\_\_\_\_