Holstep Health
Community care.
For life.

ABN 24550946840

Title of form:	Membership application

Personal details

Date of birth		**Title**		**Gender**	
Surname		**First name**		**Preferred name**	

Residential address:

Address					
State		**Postcode**		**Email**	
Phone		**Mobile**			

Mailing address:

☐ As above

Address			
State		**Postcode**	

Do you identify as Aboriginal or Torres Strait Islander?

☐ No ☐ Aboriginal ☐ Torres Strait Islander

Country of birth

Is English your preferred language for communication with Holstep Health? ☐ Yes ☐ No

If no, what language would you prefer for communication?

Current affiliation with Holstep Health:

☐ Employee ☐ Volunteer ☐ Consumer ☐ Community member ☐ Care-giver ☐ Family member

Other

Reason for membership:

☐ Actively support my local community service
☐ Interested in staying up-to-date of local health initiatives
☐ Encouraged by family/friends
☐ Voting rights
☐ Advocate for change in the health sector

Other

Are you interested in being contacted to participate in community engagement /focus groups?

☐Yes ☐No

Preferred method/s of communication: *Tick all that apply*

☐Email ☐Phone ☐SMS ☐Mail

Preferred times to attend membership events: *Tick all that apply*

☐Anytime ☐Weekdays AM ☐Weekdays PM ☐Evenings after 5pm ☐Weekends

What topics of interest and/or types of events would you be interested in participating in?

Declaration

I confirm I am aged eighteen (18) years or more and consent to my application being tabled at the next Board of Directors meeting at Holstep Health for the purpose of review and determination of membership status.

I have read through and agree to comply with the Constitution and the Member Policy & Procedures. I accept the membership liability and the requirement to guarantee Merri Community Health Services Limited trading as Holstep Health to the extent set out in the Constitution.

I declare the information I have provided on this form is true and correct and have provided full disclosure of all information required by Holstep Health, I understand that if found to have knowingly provided false information my membership status would be reviewed to the extent it may be terminated.

Signature			**Date**		
Witness name		**Witness signature**		**Date**	

Please send completed form to the Executive Assistant by email info@holstephealth.org.au or alternatively mail a hard-copy form to the below address.

Holstep Health
Attention: Executive Assistant
11 Glenlyon Road
Brunswick VIC 3056

If you have any questions, please don't hesitate to contact the Executive Assistant, Joan Wilkinson, on 0409 794 651.

Office use only

Date of receipt		**Received by**	
Tabled to BOD		**Decision by BOD**	☐Approved ☐Not approved
Entered onto register		**By (staff)**	
Acknowledgement/ Welcome letter sent:		**Date sent**	