


# APPLICATION FOR MEMBERSHIP



		<b>TAX INVOICE</b> ABN 42 961 282 521 GST Registered	
		New <input type="checkbox"/>	Renewal <input type="checkbox"/>
First Name			
Last Name			
Address			
Telephone			
Email			
<p>To reduce the use of paper the HFWA Contact newsletter is delivered electronically. Please tick <input type="checkbox"/> if you would prefer to receive a printed copy via post.</p>			
<p><b>PRIVACY:</b> HFWA membership automatically entitles you to Haemophilia Foundation Australia (HFA) membership. HFWA respects member's privacy. Your details will NOT be forwarded to other organisations, bodies, or persons without your permission. Please refer to the privacy statement on the HFWA website for details, <a href="http://www.hfwa.org/">http://www.hfwa.org/</a> Please tick <input type="checkbox"/> if you do NOT want your details forwarded to HFA.</p>			
Please indicate:		Date of Birth:	
<input type="checkbox"/> Person with bleeding disorder			
<input type="checkbox"/> Grandparents		<input type="checkbox"/> Parent of Child	
<input type="checkbox"/> Nurse		<input type="checkbox"/> Doctor	
<input type="checkbox"/> Other		<input type="checkbox"/> Special Interest	
Please indicate diagnosis details:			
<input type="checkbox"/> Haemophilia A		<input type="checkbox"/> Haemophilia B	
<input type="checkbox"/> von Willebrand Disorder		<input type="checkbox"/> Carrier	
<input type="checkbox"/> Other Factor Deficiency		<input type="checkbox"/> No Bleeding Disorder	
<input type="checkbox"/> Severe	<input type="checkbox"/> Moderate	<input type="checkbox"/> Mild	<input type="checkbox"/> vWD Type
<p><b>Please return this membership form via email or to the address below:</b></p> <p><input type="checkbox"/> Individual <input type="checkbox"/> Family (includes immediate family members) - <b>Membership \$25.00 (GST inclusive)</b> Extended family members need to take out their own membership. Membership fee can be waived in special circumstances – Please contact the HFWA office on 9420 7294.</p>			
I would like to donate:			
<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100    or \$ <b>Donations over \$2.00 are tax deductible</b>			
<input type="checkbox"/> Direct Deposit	Acct Name: The Haemophilia Foundation of WA Inc. BSB: 086 488 Acct No: 035 233 031 Ref: <i>Please include your name e.g. John Smith</i>		

<input type="checkbox"/> Credit Card	Pay securely via the Square Payment link <a href="#">here</a> or by scanning the QR code.	
<input type="checkbox"/> Cheque enclosed		

<h1>MEMBERSHIP</h1> <h2>Family History</h2>	
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Please list all family members to be included in HFWA membership.

<b>Name</b>		<b>Date of Birth</b>	
<b>Email:</b>		<b>Phone Number</b>	

Please indicate diagnosis details:			
<input type="checkbox"/> Haemophilia A	<input type="checkbox"/> Haemophilia B		
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<input type="checkbox"/> Severe	<input type="checkbox"/> Moderate	<input type="checkbox"/> Mild	<input type="checkbox"/> vWD Type

Relationship to Member:	
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<b>Name</b>		<b>Date of Birth</b>	
<b>Email:</b>		<b>Phone Number</b>	


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Relationship to Member:	
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Relationship to Member:			

<b>OFFICE USE ONLY</b>	RECEIVED	REC. NO.	ENTERED	HFA