



# MATERCARE AUSTRALIA MEMBERSHIP

PLEASE FILL OUT MEMBERSHIP FORM AND SEND TO:

MaterCare Australia - PO Box 7095, Beaumaris, VIC 3193

Title: (circle) Fr / Sr / Dr / Prof / Mr / Mrs / Miss

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

- I have skills I can offer to the work of *MaterCare Australia*
- I am a qualified *Health Professional*: \_\_\_\_\_
- Other skills: \_\_\_\_\_

## MEMBERSHIP FEES

- |   |  |
|---|--|
| <input type="checkbox"/> Obstetrician / Gynaecologist: <u>\$100</u> | <input type="checkbox"/> Friend: <u>\$25</u> |
| <input type="checkbox"/> Other Health Professional: <u>\$50</u>     | <input type="checkbox"/> Student: <u>\$0</u> |

## PAYMENTS OPTIONS

- |   |  |
|---|--|
| <input type="checkbox"/> <b>Direct Deposit</b><br>Bank: ANZ<br>BSB: 012 474<br>ACC: 347 426 908 | <input type="checkbox"/> <b>Cash / Cheque</b><br>MaterCare Australia<br>PO Box 7095<br>Beaumaris, VIC 3193 |
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*MaterCare Australia does not offer membership payment by credit card*

## DECLARATION

I accept the objectives of *MaterCare Australia* and agree to uphold and act in accordance with them – understanding that failure to do so may result in cancellation of my membership. I have read (doctors only) and hereby pledge the *Promise of the Catholic Physician*.

\_\_\_\_\_ signed