MEMBERSHIP CHANGE OF DETAILS FORM

www.kambuhealth.com.au ICN 7942

This form is for EXISTING members to update their details. Please note you can only complete this form for yourself and any dependents.

Should you wish to become a member please complete an Associate Membership form or Ordinary Membership form. Please note to be an Ordinary Member you MUST be over 18 years of age, Aboriginal and/or of Torres Strait Islander descent and ordinarily reside in the Ipswich, Boonah, Esk or Laidley area for a minimum of twelve continuous months. Kambu Health employees or contractors are not eligible for Ordinary membership.

Title: ..... First Name: ..... Surname: .....

Address: .....

..... Post Code: ..... State: .....

Please provide proof of address with your application.

Telephone: ..... Mobile: .....Email: .....

.....

Your Date of Birth: Day: ..... Month: .....Year: .....

Change of Membership Type (only tick if applicable to you):

☐ I am an Associate Member requesting change to Ordinary Membership because: .....

Declaration

I solemnly and sincerely declare that:

☐ That the details I have provided are true and correct

Other Authorisation (only mark if you agree):

☐ I authorise Kambu Health to access my medical/client records solely for the purpose of obtaining my contact details to update my membership records. No other information contained in my records may be accessed or used.

☐ I consent to receiving and/or being provided with information about Kambu Health and other relevant services, including promotional and marketing information. I understand that this may include information about programs, events, services, and other opportunities that may be relevant to me. I understand that I can withdraw my consent to receive marketing or promotional information at any time.

Please sign and return this form and email to board@kambuhealth.com.au or send enclosed in a sealed envelope to:

Att: Board Secretary, Kambu Health 27 Roderick Street, Ipswich QLD 4305 or PO Box 382, Booval Fair QLD 4304.

If the Board requires additional information in relation to this form, you will be contacted accordingly.

Your signature: ..... Date: ..... /..... / .....

Name (if signing on behalf of dependent): .....