## ASSOCIATE MEMBERSHIP APPLICATION — **NE**



www.kambuhealth.com.au

To be eligible for Associate Membership, you MUST be over 15 years of age, have an interest in the corporation and its objects, ordinarily reside in the Ipswich, Boonah, Esk or Laidley area for a minimum of six continuous months and pay the membership fee (if applicable).

Title:	First Name:		Surname:		
Address:					
			Post Code:	State:	
Telephone:		Mobile:	Email:		
				han six months add your cumentary evidence of re	
Your Date of B	irth: Day:	Month: Y	⁄ear:		
I agree to abide	e by the Corporation	n's Constitution and	the Member's Charter a	s amended from time to	time.
The Proposer an	d Seconder must be	current Ordinary Mem	nbers. Membership is curr	ent after Board approval.	
Referring Ordin	nary Member (Propo	oser): Name:		Signature:	
Seconder Ordi	nary Member:	Name:		Signature:	
be requested re	return this form en	closed in a sealed en	postal addresses.	y Secretary with such info alth, Registered Offic 4.	·
information in the outcome o	relation to your app f your application w	lication, you will be o ill be communicated	contacted accordingly. Fo to you by email or mail.	deration. If the Board requ Illowing consideration of a Please note it is the resp g: ceo@kambuhealth.com	all information, onsibility of all
Your signature:			<u>.</u>		
Date: /	/				