



10 Ernest Street
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Innisfail Q 4860
Phone: 07 40614 477 Fax: 07 40612 749

ABN: 68 011 074 347

MAMU HEALTH SERVICE MEMBERSHIP APPLICATION
(Please print this form, complete and return with payment)

Name: _____

Address: _____

Occupation: _____

Date of Birth: _____ Place of Birth: _____

Family Cultural Background: _____

Aboriginal Torres Strait Islander Non Indigenous

Interested in becoming a member: _____

I wish to become a financial member of Mamu Health Service Limited.

Any person is eligible to become a Member if the person:

- (a) is aged 18 years or over
- (b) is an Aboriginal and/or Torres Strait Islander Person
- (c) is a resident in the Geographic Service Area
- (d) is not a contractor to the Company
- (e) in the event of liquidation, I understand that I, as a member will re required to pay a maximum of \$10.00 towards the company's liability.

Upon being accepted, I undertake to be bound by the Company's articles of association and decisions made by the Board of Directors from time to time.

Enclosed is \$2.00 membership fee, which is to be paid annually.

Signature: _____ Date: _____

Office Use Only	
Date BOD Meeting:/...../.....	Membership Number:
Receipt Number:	Admin Signature: