APPLICATION FOR MEMBERSHIP

Please notify the office of any change of details

Name: _____ **D.O.B:** _____

Address: _____

Phone Numbers:

Home: _____ **Work:** _____ **Mobile:** _____

Membership Eligibility:

☐ Over the age of 18 years

☐ Aboriginal or Torres Strait Islander person

☐ Who live in Mareeba town and district, including Dimbulah, Biboohra, Mount Molloy and Chillagoe and have lived there for 6 months or more.

☐ I have read and understood the Rule Book of Mulungu Aboriginal Corporation Primary Health Care Service.

I declare that I meet the above criteria for membership with Mulungu Aboriginal Corporation and pledge to abide by the Rules of the Association.

Signature: _____ **Date:** _____

OFFICE USE ONLY

Date Received ____/____/____

Date Membership Passed ___/___/____

Membership Accepted ☐ Membership Declined ☐

Rule Book: Posted YES/NO Date Posted _____

_____ _____

Signature of Chairperson **Signature of Director**