Health Care Consumers' Association ACT INC
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Driving better health outcomes through consumer empowerment

Individual Membership Application 2015-2018

Personal details:

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Other (*please specify*) _____

Given Name: _____ **Last name:** _____

Contact details:

Address: _____

_____ **Post Code:** _____

Phone: _____ **Mobile Phone:** _____ **Fax:** _____

Email Address: _____

Membership type :

I apply for the following type of membership and confirm that I am eligible to be a member of that type.

Please select a membership type:

☐ Individual ($20) ☐ Concession/Low income ($10) ☐ Trained Consumer Rep ($10)

I apply for membership of the Health Care Consumers' Association ACT Inc and I agree to support the objectives of the Health Care Consumers' Association of the ACT and its Constitution (which can be viewed at www.hcca.org.au). I grant my consent to be photographed or videotaped during my attendance at HCCA events, and for these images to be used in promotional and other relevant materials by HCCA.

Signature: _____ **Date:** _____

Payment details:

☐ * I enclose a cheque for $_____ (inc GST)

☐ * Cash payment (in person) $_____

☐ * I have paid by credit card over the phone $_____ (inc GST) Date: _____
(Please note that SHOUT (Self Help Organisations United Together) processes credit card payments on our behalf)

☐ * I have paid by EFT deposit $_____ (inc GST) Date: _____
If paying via EFT please deposit into the following account:

Account name: **Health Care Consumers Association** BSB: **112-908** Account no: **410919896**

☐ * I wish to donate to HCCA for $_____

* Please tick whichever is applicable. Membership fee covers the period ***1 July 2015 to 30 June 2018***.

To help us build a profile of our members we ask that you provide additional details. This is optional but we would appreciate your assistance. This information remains confidential and will be used for internal processes only.

Demographics: *(if you are registering as a group please indicate the demographics of your membership)*

Age: ☐ 18 to 30 ☐ 30 to 45 ☐ 45 to 60 ☐ 60 +

Gender: ☐ Male ☐ Female

Level of education: ☐ Secondary ☐ Tertiary ☐ Postgraduate

Are you from a culturally or linguistically diverse background? ☐ Yes

If Y**es** please indicate your background _____

Are you from an Indigenous or Torres Strait Islander background? ☐ Yes

If you are registering as a group, how many members do you have? _____

Community involvement:

Other organisations of which you are a member: _____

_____

_____

What committee/s have you been on in the past for HCCA?

Name of committee **Year**

_____

_____

Areas of interest in health care:

☐ **Health Rights** ☐ **Medication Safety**

☐ **Complaints Management** ☐ **Research and Development**

☐ **Improving Service Delivery** ☐ **Other** (*please specify*)_____

_____

_____

_____

Are you interested in helping HCCA with any of the following?

☐ **Commenting on documents and policies** ☐ **Health policy development**

☐ **Attending occasional meetings or seminars** ☐ **Sharing your stories with others**

☐ **Becoming a consumer representative** ☐ **Organisational governance**

☐ **Other** (*please specify*) _____

_____

_____