

MEMBERSHIP FORM 2018-2021

Your Community Health welcomes you to become involved in the way our health services are planned and delivered.

Who can join?

Anyone who is over 18 years of age and meets one of these criteria can become a member. Please tick the boxes that apply to you:

- I live, work, play or study in northern Melbourne
- I am a client of Your Community Health
- I have a connection with Your Community Health

In accordance with our Constitution, a member's liability is limited to a guaranteed amount. In the unlikely event the organisation is wound up, each Member and former Member in the previous year must contribute up to one dollar (\$1).

What are the benefits of membership?

As a Your Community Health Member you will get:

- Invitations to the Annual General Meeting as a voting Member
- The opportunity to stand for election to the Board of Directors and vote in Board elections
- *Your News*, a community newsletter with updates on our activities, twice a year
- Written or email communications from the CEO about other important announcements or events we are holding
- A copy of our Quality Account & Annual Report

How can I become a member?

Complete this form and send it to the CEO, Your Community Health, 125 Blake Street, Northcote, VIC 3070 or leave this form at Reception your next visit. You can also complete this form online www.yourcommunityhealth.org.au.

Membership applications will be reviewed by the Board and welcome packs sent to new members. All approved memberships will expire in June 2021 when members will be invited to renew their membership.

Your details

Personal information provided will only be used and disclosed in accordance with the law.

Title:		First Name:			
Last Name:				Date of birth:	
Address:					
Suburb:				Postcode:	
Phone:		Email:			

Mailing address:
125 Blake Street
East Reservoir VIC 3073

T (03) 8470 1111
F (03) 8470 1107
E info@yourcommunityhealth.org.au

YOURCOMMUNITYHEALTH.ORG.AU



Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Would rather not say		
Do you identify as Aboriginal and/or Torres Strait Islander?	Yes	No	
Do you have a disability?	Yes	No	
Are you a carer?	Yes	No	
Do you currently use any of our services?	Yes	No	
Do you volunteer with us?	Yes	No	
Do you have children under 12 years of age?	Yes	No	
Do you need an interpreter?	Yes	No	
If yes, what language?	Yes	No	
Can we contact you about participating in events, surveys or workshops?	Yes	No	
What is your country of birth?	Yes	No	
How would you like us to communicate with you?	Phone	Email	Post
Availability:	Anytime	Weekdays 10-2pm	Evenings after 5pm
The reason I want to become a member is:			
As a member, how do you think you could contribute to Your Community Health?			

Certify: I confirm that I wish to become a member of Your Community Health and meet the criteria listed above. I agree to comply with the constitution and regulations of the company and undertake to contribute \$1 to the company's property if the company is wound up.

Signature: _____

Date: _____

Thank-you for your application. The Board of Directors will review your application and you will be notified of the result.

FOR OFFICE USE ONLY	
Date received:	Received by:
Date Considered by Board:	Decision by Board:
Entry in Register:	Welcome pack sent:

