



## MEMBERSHIP APPLICATION FORM

### PERSONAL DETAILS:

Title:  Mr  Mrs  Ms  Miss  Other

Surname:

Given Names:

Date of Birth: DD  MM  YYYY

### POSTAL DETAILS:

Address:

Suburb:  Post Code:

### CONTACT DETAILS:

Daytime Telephone:  Mobile:

Email:

Preferred Method of Communication:  Telephone  Mobile  Email  Postal Address

### DIAGNOSIS DETAILS:

I am joining HFWA Because I have:  Haemophilia A  Haemophilia B  vWD  Carrier  
 Other Factor Deficiency  No Bleeding Disorder  
 An interest as a health professional

Bleeding Disorder Severity  Severe  Moderate  Mild  vWD Type

### ANNUAL SUBSCRIPTION:

\$25.00 (GST Inc.) Application – Single  or Family Membership   
 Please forward a receipt (for tax purposes)

\* Being a member of the HFWA entitles you to receive newsletters, access to peer support activities, the national newsletter from HFA, our library resources, subsidised medic alert devices and shoe subsidies.

Signed:  Date:

### PRIVACY

HFWA respects members' privacy. Your details will NOT be forwarded to other organisations, bodies or persons without permission. Please note, HFWA membership automatically entitles you to free membership with Haemophilia Foundation Australia. Tick this box if you do NOT want your details forwarded to HFA

I do NOT want my details forwarded to HFA

CITY WEST LOTTERIES HOUSE  
2 DELHI STREET  
WEST PERTH WA 6005

[Http://www.hfwa.org](http://www.hfwa.org) e-mail: [office@hfwa.org](mailto:office@hfwa.org)  
MEMBER OF THE HAEMOPHILIA FOUNDATION AUSTRALIA  
Should you wish to transfer your payment directly to our bank, the details are:  
National Australia Bank – Wembley, BSB #: 086-488 Account #: 035233031  
Donations over \$2.00 are Tax Deductible



## MEMBERSHIP APPLICATION FORM

<b>FAMILY HISTORY:</b>	List all family members to be included in HFWA membership
<b>Name:</b>	<input type="text"/>
<b>Date of Birth:</b>	DD <input type="text"/> MM <input type="text"/> YYYY <input type="text"/>
<b>DIAGNOSIS DETAILS:</b>	<input type="checkbox"/> Haemophilia A <input type="checkbox"/> Haemophilia B <input type="checkbox"/> vWD <input type="checkbox"/> Carrier <input type="checkbox"/> Other Factor Deficiency <input type="checkbox"/> No Bleeding Disorder <input type="checkbox"/> An interest as a health professional <input type="text"/>
<b>Bleeding Disorder Severity</b>	<input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> vWD Type
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