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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **APPLICATION FOR 2020/21 MEMBERSHIP** | | | | | | | | | |
|  | **TAX INVOICE**  ABN 42 961 282 521  GST Registered  **New**  **Renewal** | | | | | | | | |
| Title |  | | | | | | | | |
| First Name |  | | | | | | | | |
| Last Name |  | | | | | | | | |
| Address |  | | | | | | | | |
| Telephone |  | | | | | | | | |
| Email |  | | | | | | | | |
| To reduce the use of paper, please tick  if you would prefer to receive the newsletter electronically.  Please contact the HFWA office (9420 7294) if you wish to pay by credit card***.***  PRIVACY:  HFWA membership automatically entitles you to Haemophilia Foundation Australia (HFA) membership. HFWA respects member’s privacy. Your details will NOT be forwarded to other organisations, bodies, or persons without your permission. Please refer to the privacy statement on the HFWA website for details, <http://www.hfwa.org/> Please tick 🞏 if you do NOT want your details forwarded to HFA. | | | | | | | | | |
| Please indicate: | | | | |  | | | | |
| Person with bleeding disorder | | | | |  | | | | |
| Grandparents | | | | | Parent of Child | | | | |
| Nurse | | | | | Doctor | | | | |
| Other | | | | | Special Interest | | | | |
| **Please return this membership form via email or to the address below:**  Individual  Family (includes immediate family members) - **Membership $25.00 (GST inclusive)**  Extended family members need to take out their own membership.  Membership fee can be waived in special circumstances – Please contact the HFWA office on 9420 7294. | | | | | | | | | |
| I would like to make a donation of: | | | | | | | | | |
| $25  $50  $100 or $      ***Donations over $2.00 are tax deductible*** | | | | | | | | | |
| Direct Deposit | | Acct Name: The Haemophilia Foundation of WA Inc. | | | | | | | Cheque enclosed |
|  | | BSB: 086 488  Acct No: 03 523 3031  Ref: *Please inc. your name e.g. John Smith* | | | | | | | |
| Signature: | |  | | | | | Date: |  | |
| **OFFICE**  **USE**  **ONLY** | RECEIVED | REC. NO. | | ENTERED | | HFA | |
|  |  | |  | |  | |

**Haemophilia Foundation of WA Inc.** **Haemophilia Foundation of WA Inc**.

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| **APPLICATION FOR 2020/2021 MEMBERSHIP**  **Family History** | | | | | |
| Please list all family members to be included in HFWA membership. | | | | | |
| **Name** |  | | | | |
| **Date of Birth** |  | | | | |
| Please indicate diagnosis details: | | | |  | |
| Haemophilia A | | | | Haemophilia B | |
| von Willebrand Disorder | | | | Carrier | |
| Other Factor Deficiency | | | | No Bleeding Disorder | |
| Severe | | Moderate | | Mild | vWD Type |
| Relationship to Member: | | |  | | |
| **Name** |  | | | | |
| **Date of Birth** |  | | | | |
| Please indicate diagnosis details: | | | |  | |
| Haemophilia A | | | | Haemophilia B | |
| von Willebrand Disorder | | | | Carrier | |
| Other Factor Deficiency | | | | No Bleeding Disorder | |
| Severe | | Moderate | | Mild | vWD Type |
| Relationship to Member: | | |  | | |
| **Name** |  | | | | |
| **Date of Birth** |  | | | | |
| Please indicate diagnosis details: | | | |  | |
| Haemophilia A | | | | Haemophilia B | |
| von Willebrand Disorder | | | | Carrier | |
| Other Factor Deficiency | | | | No Bleeding Disorder | |
| Severe | | Moderate | | Mild | vWD Type |
| Relationship to Member: | | |  | | |
| **Name** |  | | | | |
| **Date of Birth** |  | | | | |
| Please indicate diagnosis details: | | | |  | |
| Haemophilia A | | | | Haemophilia B | |
| von Willebrand Disorder | | | | Carrier | |
| Other Factor Deficiency | | | | No Bleeding Disorder | |
| Severe | | Moderate | | Mild | vWD Type |
| Relationship to Member: | | |  | | |