



2010

ICA WA Membership Form

Please complete ALL sections of the following membership form.

NAME

Title: Mr Mrs Ms Miss Dr Professor

Surname: _____

Given Name: _____

POSTAL ADDRESS

Street: _____

Suburb: _____ Postcode: _____

State: _____ Country _____

CONTACT DETAILS

Place of employment: _____

Telephone (Business): _____

Telephone (Home): _____

Telephone (Mobile): _____

Membership fee covers automatic membership to the Australian Infection Control association Inc (AICA)

Please provide the email address you would like to be used to send all relevant AICA and ICWA correspondence to:

NB: Membership year is January 1 to December 31. Initial membership is reduced to half the annual fee where membership commences after July 1. Memberships are non-transferable. All membership fees inclusive of GST

TYPE OF MEMBERSHIP New Membership Membership Renewal

Do you require a Member's badge (\$5.00) Yes No

Do you require a Membership pack (new members only)? Yes No

Ordinary - Any healthcare professional in Western Australia with an interest in infection control who is able to contribute to the objectives of the Association.

Fee: Australia \$110.00 for 1 year \$330.00 for 3 years

Associate - Any healthcare professional outside Western Australia with an interest in infection control who is able to contribute to the objectives of the Association.

Fee: Australia \$110.00 for 1 year \$330.00 for 3 years Overseas AUD\$125.00 for 1 year \$375.00 for 3 years

Commercial - A person representing a company or business, the products of which are associated with infection control, and who is able to contribute to the objectives of the Association and who is invited by the Association to become a member.

Fee: Australia/Overseas \$150.00 for 1 year \$450.00 for 3 years

TOTAL FEE DUE \$ _____

PAYMENT DETAILS (Do not send cash)

Money Order Cheque (Dishonoured cheques expenses will be met by the member) Credit Card

Please debit my credit card for the amount of \$ _____

Visa MasterCard Bankcard

Card Number: _____

Expiry Date: ____ / ____

Name on card: _____

Signature: _____

Date: ____ / ____ / ____

The primary purpose of collecting the personal information you supply on your application/renewal membership form is to process your membership. This information will provide accurate demographics for our association and assist in our planning for the future. We will use these details to keep you informed of future events and will not disclose this information to a third party.

PLEASE FORWARD TO: Membership Secretary The Infection Control Association of WA PO Box 674 Claremont Western Australia 6910

Office Use Only

Approved by: (Chairperson of the meeting)

Date:

New Member

Renewal

Database

Receipt Number:

Date Receipt /Membership Pack / Badge sent: