



Tax invoice 2010

ICAWA Membership Form

Please complete ALL sections of the following membership form and post/email to the Membership Secretary. If paying by direct transfer please retain the original form as your tax invoice and attach a copy of the payment transfer as receipt of payment.

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):

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

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

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 are inclusive of GST.

TYPE OF MEMBERSHIP New Membership Membership Renewal

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: \$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 (Please do not send cash)

Direct Bank Transfer Account name: ICWA Inc. BSB: 036-051 Account No: 118935

Please ensure member name is provided with the direct transfer as the identifier for the payment.

Credit Card Please debit my credit card for the amount of \$

Visa MasterCard Bankcard

Card Number: Expiry Date:

Name on card:

Signature: Date:

Money Order or Cheque (NB: Dishonoured cheques expenses will be met by the member)

Send cheques money/orders and completed form to: The Membership Secretary Infection Control Association of WA PO Box 674 Claremont 6910

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.

Office Use Only

Approved by: (Chairperson of the meeting)

Date:

New Member Renewal Database Receipt Number: Date Receipt /Membership Pack sent