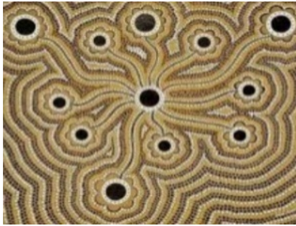

PIKA WIYA HEALTH SERVICE ABORIGINAL CORPORATION

ICN: 7355

PO Box 2021
40-46 Dartmouth Street
PORT AUGUSTA SA 5700

APPLICATION FOR MEMBERSHIP

Use this Form to Register for PWHSAC Membership

SURNAME: **FIRST NAME:**

Address: **Postcode:**

Telephone Contact Number: **Email Address:**

Date of Birth: **Place of Birth:**

Declaration:

I, ………………………………………………………………………………… the above-named applicant for membership on Pika Wiya Health Service Aboriginal Corporation (PWHSAC) declare that under Rule 17.1.1 I meet the eligibility criteria for membership and satisfy all of the following requirements:

- I am an Aboriginal person
- I am 18 years of age at the time of lodging my membership application
- My principal place of residence has been in the PWHSAC Catchment Area for a least 12 continuous months

I, confirm that the information provided is true and correct.

Signature: **Date:** ………./………./……….

My preferred method of contact is by: Post: ☐ Email: ☐

Witness Name:

Address: **Telephone:**

Signature: **Date:** ………./………./……….

OFFICE USE ONLY:			
Application received by PWHSAC:	………../………../……….	**Common Seal Affixed:**	………./………./……….
Considered by Board:	………../………../……….		
Approved by Board - Motion No:	…………………………….		
Entered onto Register of Members:	………../………../……….		