

## 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,	
<ul> <li>I am an Aboriginal person</li> <li>I am 18 years of age at the time of lodging my membership application</li> <li>My principal place of residence has been in the PWHSAC Catchment Area for a least 12 continuous months</li> </ul>	
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://	