



PIKA WIYA HEALTH SERVICE ABORIGINAL CORPORATION

ICN: 7355

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

PROXY APPOINTMENT FORM

I, _____	(Full Name of Member)
of _____	(Address of Member)

am a member of Pika Wiya Health Service Aboriginal Corporation	(Name of Corporation)
I appoint _____	(full name of proxy)
of _____	(address of proxy)

Who is a member of Pika Wiya Health Service Aboriginal Corporation, as my proxy to vote for me on my behalf at the Annual General Meeting to be held **on 24 October 2024** and at any adjournment of that meeting.

Signature of Member _____

Date _____/_____/_____

Note: Notification of a proxy must be received at PWHS administration office,
40 Dartmouth Street, Port Augusta **by 4.00pm Tuesday 22 October 2024**

OFFICE USE ONLY

Received on (date) _____/_____/_____

Eligibility verified by (name of PWHS employee) _____