

**2016/17 Membership for Nagambie HealthCare**

Family name/s ……………………………………………………………………………

First Name/s ……………………………………………………………………………

Address ……………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………………

Phone No …………………………………………………………………..

Email ………………………………………………………………………………………..........

 **Membership** 🞏 $50 Family

 🞏 $35 Single

 **Donation** 🞏 I would like to make a donation of $ …………………………..

 **TOTAL PAYMENT** - $ …………………………………

Method of payment: 🞏 cash 🞏 cheque

 🞏 credit card – Mastercard / Visa (please circle)

 Card No: ................ ……………. ……………. ……………. Expiry Date ……. / …….

🞏 Direct Debit: BSB - 063 682; Account – 10089969; Reference – your name

*Please complete and return form either by post, fax or email –*

*22 Church St, Nagambie, 3608: F: 5794 2077; E: admin@nagambiehc.org.au*



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