

South West Aboriginal Medical Service Aboriginal Corporation

Application for Admission to Membership

I the undersigned, hereby apply for admission as a member of the South West Aboriginal Medical Service Aboriginal Corporation. I declare that I satisfy the membership criteria:

Membership of the Association shall be open to adult Aboriginal persons

NAME

ADDRESS

MAILING ADDRESS

SEX **D.O.B.**

PHONE **MOBILE**

WORK **EMAIL**

If my application is accepted, I agree to abide by the Rules of the Corporation.

Signature of Applicant Date

Date of Committee Meeting that will consider the Application

Application :- Accepted Rejected

Comments

Chairperson's Signature Date