



Given Name:	
Family Name:	
Street Address:	
Suburb/Town:	
State:	Post code:
Country:	
Telephone:	Mobile:
Email:	
Occupation:	
G.P's Name:	
G.P's Address:	

Do you have Thalassaemia ?	<input type="radio"/> Yes <input type="radio"/> No	Are You Interested In <input type="checkbox"/> Information <input type="checkbox"/> Volunteering <input type="checkbox"/> Social Functions <input type="checkbox"/> Research Would you like to receive information related to our organisation? Yes No <input type="radio"/> <input type="radio"/>
If Yes, please tick the type of Thalassaemia or haemoglobinopathy that apply to you.	<input type="checkbox"/> Thalassaemia major <input type="checkbox"/> Thalassaemia intermedia <input type="checkbox"/> Haemoglobin E (Hb E) <input type="checkbox"/> Haemoglobin H <input type="checkbox"/> Sickle beta Thalassaemia	
If Not, are you a Carrier?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	

Membership Details:
 Yes, I wish to become a member of Thalassaemia Australia Inc. and agree to the Constitution of your organisation at all times. I also give permission to Thalassaemia Australia Inc. to print and produce any photograph depicting my image for editorial and document usage.

Membership Costs: Per annum - \$20 Life Member - \$200

Membership Fees & or Donations are Tax-Deductible. Please forward a cheque or money:
 Thalassaemia Australia Inc: 333 Waverley Rd, Mount Waverley VIC 3149.

Please Sign here : _____ Date: _____

Donations:
 \$10 \$ 20 \$50 Another Amount \$ _____

Office Use Only:

Welcome Sent: _____ Donation: _____ Chq/MO/Receipt: _____
 Received: _____ Cash/ Chq/MO No: _____