Queensland Stoma Association

Unit 1, 10 Valente Close, Chermside 4032
Post Office Box 370, Chermside South 4032
Website: qldstoma.asn.au
Email: newmembers@qldstoma.asn.au
Phone:(07) 3359 7570 **Fax:** (07) 3350 1882

New Member Application Form and First Order

(please send both pages single sided)

Title _____ Gender _____ Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Surname _____ Given Names _____

Postal Address _____

_____ Postcode: _____

Mobile Phone _____ Email _____ *(for service of notices)*

Date of Surgery _____ Type of Stoma: _____ Hospital _____

Person nominated to be contacted on behalf of applicant:

Name _____

Phone _____ Email _____

Office Use:

SAS ID:	Receipt #	Entered:

☐ *Please indicate if you are responsible person* signing on behalf of the applicant*

Your name: _____ *Relationship to applicant:* _____

** A **Responsible Person** can be ar parent, a child or sibling who is at least 18 years old; a spouse or defacto partner; a relative who is at least 18 years old and a member of the applicants household; a legally appointed guardian; an enduring power of attorney; or a person with whom the applicant has an intimate personal relationship.*

Privacy Notice: Your personal information is protected by law, including the Privacy Act 1988 and the Australian Privacy Principles. We will only collect personal information that is necessary for us to meet or fulfil our activities to you, including to provide you with ostomy products supported through the Commonwealth Stoma Appliance Scheme. Your personal information may be disclosed to Services Australia, the Department of Health and Aged Care, the Australian Council of Stoma Associations, your Stoma Nurse, your medical practitioner, another Stoma Association, a person authorised by you, or another third party for purposes closely related to the primary purpose for which it has been collected and where you would reasonably expect us to disclose your information. We will not share your information for marketing purposes or with overseas recipients without your consent. If you do not provide your personal information, you will be ineligible to receive support from QSA. A full copy of our Privacy Policy is available from our website qldstoma.asn.au or by requesting a copy from QSA Ltd.

Consent: By signing this form I consent to the collection of my personal information, including sensitive information, for purposes associated with my membership with QSA and for my participation in the Stoma Appliance Scheme. I give consent to QSA to share my information with the person nominated as an alternative contact in this application. I understand that I can withdraw this consent at any time by contacting QSA by phone or email.

Signature_____ **Date:**_____

I acknowledge that a full copy of the QSA Ltd Constitution, Privacy Policy, Complaints and Feedback Policy, Service User Rights and Responsibilities, and Member Code of Conduct is available on the QSA website or by contacting QSA on 07 3359 7570 or by email to admin@qldstoma.asn.au. I agree to accept the Association Rules and Member Code of Conduct, and to pay the QSA annual subscription as prescribed and any other costs incurred through my participation in the Commonwealth Stoma Appliance Scheme.

Signature_____ **Date:**_____

Initial Order *(optional use– a separate QSA order form may also be provided with application)*

Delivery Method: ☐ Pick up ☐ Postal Delivery ☐ Deliver to an Alternative Address

Alternate address: _____ Postcode: _____

	Supplier Item No.	Supplier	Description	Number of Packs
1				
2				
3				
4				
5				
6				

☐ Please register me for the QSA online ordering portal (for subsequent orders).

Email (to be used as login username): _____
Please write clearly

Office Use: Member name _____ *SAS ID* _____

Payment Information *(NOTE: initial order will be held until payment has been received):*

Annual Subscription (including SAS Access Fee):	
Postage, Packaging and Handling - $20 per order (up to 5kg)	
Donation (amounts over $2 are tax deductible)	
Total due now	

	Full member	Concession card (please attach copy)
Full year: July to June	$75	$65
Part year: Jan to June	$45	$40

Payment Method

☐ DVA Entitlement Card number _____ Expiry ☐☐ / ☐☐

☐ Cheque/Money Order

☐ Direct Deposit – First order only: BSB 064-135 ACC 1002 1069 (reference "(YOUR NAME) – NEW")

☐ Visa/Mastercard ☐☐☐☐ / ☐☐☐☐ / ☐☐☐☐ / ☐☐☐☐

Expiry date: ☐☐ / ☐☐ CCV: ☐☐☐

Cardholder Name: _____ Sig: _____

☐ Contact for payment: Name _____ Phone _____