Membership Form/Tax Invoice

ABN 42 140 529 273 All donations over $2 are tax deductible

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suburb/town \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Postcode\_\_\_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Optional) Child’s name, date of birth and disability

Do you identify as Aboriginal or Torres Strait Islander?

\_\_\_No \_\_\_Yes, Aboriginal \_\_\_Yes, Torres Strait Islander

Are you from a non-English speaking background?

\_\_\_Yes \_\_\_No

I wish to apply for (please select a category)

**\_\_\_ Full membership**

**Free for young people with disability and families**

\_\_\_ Person with disability between the ages of 18 and 25

\_\_\_ Parent/carer of a child aged under 26 years with disability

\_\_\_ Sibling

\_\_\_ Grandparent/foster parent

**\_\_\_ Associate membership**

**Full fee:** **$55 GST inc per year**

**Students & un-waged: $11 GST Inc per year**

\_\_\_ Extended family of a child/young person with disability   
 \_\_\_ Professional

\_\_\_ Service organisation   
 \_\_\_ Other (please specify)

I would like to make a donation of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONTINUED ON NEXT PAGE.

Payment enclosed or I would like to pay by:

**Direct Deposit**

Acc Name: Children and Young People with Disability Australia

BSB 633 000

Account 1396 76928

**Credit Card**

\_\_VISA \_\_Mastercard

Credit Card No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholders Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiry Date \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_ CVV\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cheque**

Payable to: Children and Young People with Disability Australia

**Declaration**

I hereby apply for membership of CYDA. I am over 18 years. If accepted as a member I agree to be bound by the rules of the CYDA Constitution\*.

**Signature**

**Date**

Send to CYDA, PO Box 172, Clifton Hill VIC 3068

Your personal information is collected only for the use of CYDA for the   
purposes of disseminating support and information to our members.