Membership Form 2024 - 2025

Membership type – please select:

☐ **Associate (AM) - $30**

☐ **Member (MM) - $50**

Member contact details:

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Other _____

Name: _____

Address: _____

Suburb: _____ **State:** _____ **Postcode:** _____

Phone (Home): _____ **Mobile:** _____

Email: _____

Member Profile:

Date of birth: _____

Level of vision: ☐ Totally blind ☐ Legally blind ☐ Low vision ☐ Sighted

Eye condition (IRD): _____

Do you have a hearing impairment? ☐ Yes ☐ No

What is your contact with inherited retinal disease?

Are you a carer? ☐ Yes ☐ No

Are you a family member? ☐ Yes ☐ No

Are you a health care professional? ☐ Yes ☐ No

Are you a researcher? ☐ Yes ☐ No

Would you like to be an active volunteer for Retina Australia? ☐ Yes ☐ No

How would you like to receive the Retina Reporter and other information?

☐ Email (pdf, Word, text provided) ☐ Print ☐ Audio CD

Payment details

Membership subscription: $_____

Tax deductible donation: $ _____

TOTAL PAYMENT: $_____

Payments can be made by Cheque or Credit Card (Mastercard or Visa only) or via direct credit.

Please make cheque payable to **Retina Australia**

CARD TYPE: ☐ Visa ☐ Mastercard

CARD NUMBER: _____/ _____ / _____ / _____

Expiry Date: ___/____ **CVV Number:** _____

NAME ON CARD: _____

SIGNATURE: _____

Direct deposit payment

Please make your payment to:

Account Name: Retina Australia **BSB:** 065 115 **Account number:** 10233087

Please include your surname and initial and type of membership (AM or MM) as your payment reference.

Please return this form with your payment via:
Email: info@retinaaustralia.com.au OR post to: Retina Australia
Ross House
247-251 Flinders Lane
Melbourne VIC 3000