

2024 - 2025 Membership Form **Fighting Blindness**

For assistance completing this form, or if you would like to pay over the phone or via direct debit, please contact us on **(03) 9650 5088**.

**Membership type**

* Associate Member (AM) - $30

This level of membership provides you with the quarterly newsletter, Retina Australia News and access to support and information.

* Member (MM) - $50

This level of membership provides you with full voting rights, which will enable you to attend and participate at general meetings and be eligible to nominate, or be nominated for, a position on the Retina Australia Board, as well as receiving all the benefits of an Associate Member.

**Member contact details**

Mr Mrs Ms Miss Dr Other………………………..

|  |  |
| --- | --- |
| Surname …………………………….. | Given Name……………………………... |
| Address | .................................................................................................................. |
| ………………………………………… State …………… | Post Code………………….. |
| Email | ……………………………………………………………………………………… |
| Phone (H)………………………………… | Phone (W) ……………………………….. |
| Mobile…………………………………….. |  |

**Member profile**

Date of Birth …………………………

Level of vision

* Totally blind
* Legally blind
* Low Vision
* Sighted

Eye condition ……………………………………………………………….

Hearing impaired

* 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 professional?

* Yes
* No

Are you a researcher?

* Yes
* No

How would you like the Retina Australia Newsletter and other information?

* Email (PDF)
* Email (text only)
* Print
* Audio CD

Are you employed?

* Yes
* No

Occupation ……………………………………………………………………….

Are you a Carer?

* Yes
* No

Would you like to be an active volunteer for Retina Australia?

* Yes
* No

**Payment details**

Membership subscription $ ……………….

Tax Deductible Donation $..................

TOTAL: ……………….

* Direct Deposit to Retina Australia, BSB 065 115, Account No. 10233087

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

* Cheque to be made payable to Retina Australia
* Credit card (Mastercard and Visa only)

Card Number ……………………………………………

Expiry Date ………………… CVV ……………….

Name on Card …………………………………………………….……..

Signature ………………………………………. Date…………………

Please return this form with your membership subscription by:

Email: info@retinaaustralia.com.au

OR Post: Retina Australia

 Ross House

 247-251 Flinders Lane

 Melbourne VIC 3000