APPLICATION FOR 2023/24 MEMBERSHIP

	New ☐ **Renewal** ☐	**TAX INVOICE** ABN 42 961 282 521 GST Registered
First Name		
Last Name		
Address		
Telephone		
Email		

To reduce the use of paper the HFWA Contact newsletter is delivered electronically.
Please tick ☐ if you would prefer to receive a printed copy via post.

PRIVACY:
HFWA membership automatically entitles you to Haemophilia Foundation Australia (HFA) membership. HFWA respects member's privacy. Your details will NOT be forwarded to other organisations, bodies, or persons without your permission. Please refer to the privacy statement on the HFWA website for details, http://www.hfwa.org/
Please tick ☐ if you do NOT want your details forwarded to HFA.

Please indicate:	Date of Birth:
☐ Person with bleeding disorder	
☐ Grandparents	☐ Parent of Child
☐ Nurse	☐ Doctor
☐ Other	☐ Special Interest

Please indicate diagnosis details:			
☐ Haemophilia A		☐ Haemophilia B	
☐ von Willebrand Disorder		☐ Carrier	
☐ Other Factor Deficiency		☐ No Bleeding Disorder	
☐ Severe	☐ Moderate	☐ Mild	☐ vWD Type

Please return this membership form via email or to the address below:

☐ Individual ☐ Family (includes immediate family members) - **Membership $25.00 (GST inclusive)**

Extended family members need to take out their own membership.

Membership fee can be waived in special circumstances – Please contact the HFWA office on 9420 7294.

I would like to donate:

☐ $25 ☐ $50 ☐ $100 or $ ***Donations over $2.00 are tax deductible***

☐ Direct Deposit	Acct Name: The Haemophilia Foundation of WA Inc. BSB: 086 488 Acct No: 035 233 031 Ref: *Please include your name e.g. John Smith*

City West Lotteries House, 2 Delhi Street, WEST PERTH WA 6005 P: 08 9420 7294 E: office@hfwa.org W: www.hfwa.org
ABN: 42 962 282 521 Donations over $2 are Tax Deductible Member of Haemophilia Foundation Australia

☐ Credit Card	Pay securely via the Square Payment link here or by scanning the QR code.	
☐ Cheque enclosed		

2023/2024 MEMBERSHIP
Family History

Please list all family members to be included in HFWA membership.

Name		**Date of Birth**	
Email:		**Phone Number**	

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☐ Severe	☐ Moderate	☐ Mild	☐ vWD Type

Relationship to Member:	

Name		**Date of Birth**	
Email:		**Phone Number**	

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Relationship to Member:			

OFFICE USE ONLY	RECEIVED	REC. NO.	ENTERED	HFA

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