**MEMBERSHIP FORM 2024-2027**

**Why become a member?**

Membership allows you to take part in how Your Community Health is run. This includes:

* Having a say and contributing your ideas through Your Community Health’s events, workshops, forums, focus groups and member meetings
* Staying informed about local issues through our newsletters and Quality Account and Annual Report
* The opportunity to stand for election to the Board of Directors and voting in Board elections at our Annual General Meeting

**Who can join?**

To become a member you need to be over 18 years of age and at least one of the following:

* Live, work, play or study in northern Melbourne
* Have a connection with Your Community Health
* Be a client of Your Community Health

**How can I become a member?**

Complete this form and:

* send it to the Chief Executive Officer, Your Community Health, 125 Blake Street, Reservoir VIC 3073, or
* Leave this form with the reception team at your next visit, or
* Complete this form online at [www.your](http://www.your)communityhealth.org.au/membership.

Membership applications will be reviewed by the Board of Directors. If your membership is accepted, a welcome pack will be sent to you. All approved memberships will expire in June 2027 when members will be invited to renew their membership.

In the unlikely event that the organisation needs to shut down, every member is required to contribute $1.00 to the assets of the company while they are a member or within one year afterwards.

**Your details**

Personal information provided will only be used and disclosed in accordance with the law.

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|  **Contact Details**  |
|  **Title:** |  **Given Name:** |  **Family Name:** |
|  **Street Address:** |
|  **Suburb:** |  **State:** |  **Post Code:** |
|  **Email:** |
|  **Home Phone:**  |  **Mobile No:** |
|  **Preferred Communication:   Email   Post   Both** |

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|  **Additional Information** |
| **Gender** | **Female****Male** **Transgender** **Non-binary****Would rather not say****Other (please specify)** | **Your pronouns** | **She/Her/Hers****He/Him/His****They/Them/Theirs****Something else (please specify)** |
| **Do you identify as Aboriginal and/or Torres Strait Islander?** | **Yes   No   Prefer not to say** |
| **Country of Birth:**  |  |
| **Languages spoken:** |  |
| **Do you need an interpreter?** | **Yes   No** |
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| **Do you have a disability?** **Are you a carer?****Do you currently use any of our services?****Do you volunteer with Your Community Health?** | **ð Yes** **ð** **No****ð Yes** **ð** **No****ð Yes**  **ð** **No****ð Yes** **ð** **No** |
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| **The reason I want to become a member is:** |
| **As a member, how do you think you could contribute Your Community Health?**  |

**Certify:** I confirm that I wish to become a member of Your Community Health and meet the criteria listed above. I agree to comply with the constitution and regulations of the company and undertake to contribute $1 to the company’s property if the company is wound up.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **FOR OFFICE USE ONLY** |
| Date of received:  | Received by:  |
| Considered by Board:  | Decision by board:  |
| Entry in register: Membership Number | Welcome pack sent:  |