

MEMBERSHIP APPLICATION

TO HELP US - PLEASE PRINT

Date : _____

Please underline appropriate Title

Mr Mrs Miss Ms Dr Sr (Family Name) _____

Given Names : _____

HOW DO YOU LIKE TO BE ADDRESSED ?(Given Name etc) _____

ADDRESS: Street or P.O. Box _____

City _____ State _____ Postcode _____

OCCUPATION / PREVIOUS OCCUPATION: _____

TELEPHONE NUMBER : Home () _____ Work () _____

Mobile (_____) Email: _____

Type

IBS Type

A = Alternating between Diarrhoea and Constipation predominant

A+= Alternating plus pain and / or bloating

B = Pain and or bloating

C = Constipation predominant C+= Constipation plus pain and / or bloating

D = Diarrhoea

D+= Diarrhoea plus pain and / or bloating

SIGNATURE : _____ Date of Birth _____ / _____ / _____

Fees

The fees as listed are available until 1st April 2006. After that date enquiries phone to our contact officer on 07 3907 0527.

Please mail this application to IBIS PO Box 7092 Sippy Downs QLD 4556

Joining Fee : 10.00

Annual Membership : 22.00

Discount for Social Security Beneficiaries of \$3.00-

Sub - Total : 32.00

please quote your pension number: _____ Pension Discount : -

Donations of \$2 or more may be claimed as an income tax deduction + Donation : _____

and will be greatly appreciated.

Bankcard/ Mastercard/Visa Please underline type

TOTAL \$: _____

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Cardholder Name: _____ Signature : _____ Expiry Date : _____ / _____

Would you like to receive your newsletter by email : Name _____

Email is sent in Adobe PDF.

Email address: _____

For Office Use: Membership No. : _____

Receipt No. : _____

Authorisation No.: _____