



# APPLICATION FOR MEMBERSHIP

**Company/Organisation:** \_\_\_\_\_

**Main Contact Person(s):** (and State / Territory in which they will represent you) \_\_\_\_\_

**Address of Facility:** \_\_\_\_\_

(Providers with more than one location please provide all location details) \_\_\_\_\_

**Scheme Provider Nos:** (eg Comcare 1111) \_\_\_\_\_

**Telephone(s) for main contacts:** \_\_\_\_\_

**Facsimile(s) for main contacts:** \_\_\_\_\_

**E-mail addresses:** \_\_\_\_\_

**Website:** \_\_\_\_\_

**Type of membership being applied for:**

Full

Associate

Honorary

**Major Services Provided:** \_\_\_\_\_

**Occupational Areas or Industries in which experienced:** \_\_\_\_\_

**Number EFT delivering OR services in each State in which you operate:** \_\_\_\_\_

**Signed (Agency Principal):** \_\_\_\_\_

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

**Proposer:** \_\_\_\_\_

**Secunder:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Name:** \_\_\_\_\_

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

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

**Position:** \_\_\_\_\_

**Position:** \_\_\_\_\_

**Company:** \_\_\_\_\_

**Company:** \_\_\_\_\_

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

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

The Proposer and Secunder must be full members of the ARPA branch to whom the applicant is known.