



ME/CFS Australia (Victoria)

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ARBN: 136 448 050

IAN: A0016974N

DGR: 900279668

CONDITIONAL TAX INVOICE

Membership Application

ME/CFS Australia (Victoria) is a **not-for-profit charitable organisation** dedicated to providing information, support and advocacy for the ME/CFS community in Victoria, Tasmania and the Northern Territory.

Our services include a support and information line staffed by volunteers with knowledge of ME/CFS; support groups run across the three states; and an online message board to post questions, share ideas and learn from others' experiences; an extensive free website with the latest high quality information on ME/CFS.

As a member of ME/CFS Australia (Victoria) you are also entitled to:

- Receive four issues of our informative quarterly journal 'Emerge';
- Participate in our small-group teleconferencing sessions;
- Participate in our self-help groups at a reduced cost;
- Access information on ME/CFS support groups;
- Borrow books, CDs and DVDs from our ME/CFS resource library;
- Receive personal support and advocacy from ME/CFS Australia (Victoria) staff; and
- Participate in events and seminars organised by ME/CFS Australia (Victoria).

If you would like to become a member of ME/CFS Australia (Victoria) please fill in the following information.

Membership fees allow us to continue providing our services, raise awareness of ME/CFS through community education, and participate in political lobbying. If you do not wish to join as a member your donation would be greatly appreciated to help us continue to provide our important services.

Contact Information

Mr Ms Surname: _____
Mrs Miss Given Names: _____
Address: _____
 Suburb: _____ State: _____ Postcode: _____
Phone: (H) _____ (M) _____ (B) _____
Fax: _____ How did you find out about us: _____
Email: _____

Personal Information

Date of birth: _____ Country of birth: _____
Year arrived in Australia (if applicable): _____
Do you personally have ME/CFS? Yes No
Name of diagnosing doctor: _____
Name of treating doctor: _____
Occupation (past or present): _____
Are you a health care professional? Yes No
Are you a parent/carer of a person with ME/CFS? Yes * No

*Please fill in details of person with ME/CFS:

Name: _____
Date of birth: _____

Office Use Only: Notes/additional documents

