**ASSOCIATE ORGANISATION MEMBERSHIP**

**2022-23 APPLICATION FORM**

**NB**: Individuals are eligible for free Individual Membership and do not complete this form. Instead, ask for a Individual Membership Application.

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| **CONTACT DETAILS** \*Your name and at least one contact address/email is required | |
| Organisation/group: |  |
| Type of organisation/  group: (if applicable) |  |
| Contact person: | Mr  Mrs  Ms  Miss  Mx  Other ......................................... |
| First Name |  |
| Surname: |  |
| Preferred Pronouns | He/Him  She/Her  They/Them  Other……………. |
| Address: |  |
| Postal Address: |  |
| Email: |  |
| Office Phone: |  |
| Mobile Phone: |  |
| Other contact: |  |
| Website: |  |

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| --- | --- | --- |
| **INCLUSIONS/ENTITLEMENTS** | | |
| - Quarterly newsletters - Your logo, info and link on our website  - Promotion of your events - Use of meeting space  - Partnership and collaboration - Election to the Network’s Board | | |
|  | | |
| **COMMUNICATION PREFERENCES:** | | |
| What is the **BEST** way for us to contact you? | Email  Home/business Phone  Post  Text  Mobile Phone | |
| Do you want to receive Newsletters and other information? | Yes by email  Yes by post | |
| How should we send information about AGMs etc? | Home/business Address  Postal Address  Email | |
|  | | |
| **ANNUAL CONTRIBUTIONS** | | |
| In order to support the Network’s core programs and enable beneficial relationships with like-minded organisations and groups there is a small annual contribution per organisation/group or individual.  Organisations/groups and individuals who feel they are unable to pay their contribution may be eligible may request a contribution waiver or reduction. | | |
| **Organisation/Group**  **Annual Funding Level** | | **Contribution Rate (tick appropriate box)** |
| < $100,000 | | $60.00 |
| > $100,000 | | $120.00 |
|  | | |
| **Payment methods** | | |
| **Cheque**  **EFT** | Made out to: ACT Mental Health Consumer Network  Account Name: ACT Mental Health Consumer Network  Account Number: 10168614  BSB: 062-919 | |

Please return your completed application to: ACTMHCN, Reply Paid 469, Civic Square, ACT 2608