



**CYSTIC FIBROSIS QUEENSLAND INC.**

ABN: 97 010 549 667 (DGR Endorsed)

**12 Month Membership Form**

07 3359 8000

FREECALL: 1800 670 990

Membership Details (Choose one)	
I have a child with CF	Go to 1
I have CF	Go to 2
My relationship with a person with CF	(please specify)
1. Child's details: (the 'client') Parent/s becomes member on behalf of the child.	
First Name	Last Name
Date of Birth	Gender
I would like my child to receive a birthday card each year in the month of their birth	Yes No
2. Member details (the 'member')	
First Name	Last Name
Company Name (Corporate Membership)	
Date of Birth (if you are the person with CF)	
Address No. and Street	
Suburb	State Postcode
Phone number	
Email .....	
Tick if you <b>do not wish to receive</b> any <b>information</b> about or from CFQ other than membership information	
Please send me information about leaving a donation in my will to support CFQ	
Please contact me regarding volunteering opportunities for CFQ	
3. Membership Categories	Criteria
Concession \$15.00 Health Care Card No. ....	- Applicant or their child must have a valid Health Care Card - Families with one or more children with a valid Health Care Card
Standard Membership \$30.00	- For immediate family of anyone under 18yo with CF - CF adults with no Health Care Card - CFQ staff and volunteers
Friend of CFQ \$50.00	- I wish to support CFQ
Corporate Member \$200.00	- Businesses wishing to support CFQ
<b>I wish to make a Donation</b> (Donations of \$2 or more are tax deductible)	\$20.00 \$50.00 \$100.00 Other \$ Please provide me with a Tax Receipt
4. Payment Method	
Credit Card type: Visa MasterCard	Name on Card:
Card No:	Expiry Date Signature:
Direct transfer to CFQ - BSB: 034-036 Account number: 291 909 Include reference: <i>lastnameMshp</i>	

Thank you for your Membership application  
Please send completed application to [services@cfqld.org.au](mailto:services@cfqld.org.au), or PO Box 86, Toowong Business Hub, Qld 4066

Date Received: / /