



MEMBERSHIP FORM

Applicants Name: _____

Address: _____

_____ Post Code: _____

Telephone: (B) _____ (H) _____ (M) _____

Email: _____ @ _____

Endorsing Member Details:

Name: _____

Signed: _____

Dated: ____/____/____

Membership Fees: (Please tick)

\$5 per person (GST Inclusive)

Your payment details: (Please tick)

Cash Only

I enclose my cheque/money order payable RELATEWELL

Please debit my credit card \$ _____ Mastercard Visa

Cardholder's Name:																				
Signature:															Expiry Date:					
															/					

Please email or mail this form as soon as possible:

Family Relationships Institute Inc. (RELATEWELL)

21 Bell Street, Coburg Vic 3058

T: (03) 9354 8854 F: (03) 9354 8860 E: relate@relatewell.org.au WWW: www.relatewell.org.au

Office Use Only

Receipt No.: _____ Date: ____/____/____ Amount Paid: \$ _____ Sgd: _____