



Australian Health Care Reform Alliance

C/- PO Box 280 Deakin West ACT 2600 ABN 64 051 645 674
www.healthreform.org.au

APPLICATION FOR MEMBERSHIP OF AHCRA

Name of organisation:

Contact person: **Position:**

Address:

Suburb: **State:** **Postcode:**

Phone: **Fax:**

Mobile:

Email contact address:

I confirm that our organisation supports the aims of the Australian Health Care Reform Alliance as described on www.healthreform.org.au and wishes to become a member.

Signed:

Date:

Please fax completed form to 02 6285 4670 or email info@healthreform.org.au . Your application will be considered at the next AHCRA Executive meeting. You will be advised of the outcome and if successful, you will be issued with a tax invoice.