

YOU INC. MEMBERSHIP RENEWAL 2019/20

Statement of Confidentiality

PLEASE USE BLOCK LETTERS

Mr – Mrs – Ms – Miss – Master – Dr – Other (Please circle)

First Name

Surname

Address

..... Postcode.....

Phone Home Mobile

E-mail Address

REASON FOR SURGERY

- | | | | |
|----------------------|--------------------------|-----------------|--------------------------|
| Ulcerative Colitis | <input type="checkbox"/> | Crohn's Disease | <input type="checkbox"/> |
| Familial Polyposis | <input type="checkbox"/> | Congenital | <input type="checkbox"/> |
| Spina Bifida | <input type="checkbox"/> | Cancer | <input type="checkbox"/> |
| Trauma | <input type="checkbox"/> | | |
| Other (please state) | | | |

.....

YEAR OF STOMA.....

TYPE OF STOMA/S (tick all applicable)

Annual Membership (now optional) – please complete

- | | | | |
|--------------------------|--------------------------|---------|---------|
| Colostomy ^{2/2} | <input type="checkbox"/> | | |
| Ileostomy | <input type="checkbox"/> | \$15.00 | \$..... |
| Urostomy | <input type="checkbox"/> | | |
| J Pouch | <input type="checkbox"/> | | |
| Pensioner – yes/no | | \$10.00 | \$..... |
| (Pen Number) | | | |
| Professional Consultant: | | \$15.00 | \$..... |
| Interested person: | | \$15.00 | \$..... |
| Donation: | | \$ | \$..... |
| TOTAL: | | \$..... | |

Where did you hear about YOU Inc?

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Please share a little information about your experience (i.e. surgery), if you wish

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Membership period 1st July – 30th June annually.

Payment can be made directly to Young Ostomates United Inc. (BSB: 063-142; A/C 0093970)

Please complete this renewal form and either e-mail it to helshae@hotmail.com
or print off and post to

YOU Inc, P.O. Box 1433 MDC, Narre Warren, Vic 3805