Euroa Health

Membership Application form

Family Name: _____ First Name: _____

Address: _____

Telephone: _____ Mobile: _____

Email: _____

All correspondence will be sent via email unless otherwise requested (below)

I do not want to receive correspondence via email (please tick) ☐
I am a Euroa Health Inc staff member (please tick) ☐

Membership fees are for the full financial year July to June or calculated on a pro-rata monthly basis.

Euroa Health Inc Membership: $ _____ $30.00 Single/$50.00 Family

Gym Membership: $ _____ $50.00 Single/$90.00 Family

Gym Assessment: $ _____ $30.00 per person

(One off payment for new members (through our exercise Physiologist)

I wish to make a donation: $ _____

Total: $ _____

Payment options: Cash, Cheque or EFTPOS

Please ensure each family /additional family member completes the Gym Member Medical Profile form.

Additional Family members:

1: Family Name: _____ First Name: _____

2: Family Name: _____ First Name: _____

3: Family Name: _____ First Name: _____

4: Family Name: _____ First Name: _____

5: Family Name: _____ First Name: _____

(Additional family members must live at same address as above)