AHCWA Membership Application Form

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| Your Organisation’s Details: |
| Full legal name of Organisation: |
|  |
| Physical Address: |  |
| Postal Address: |  |
| Phone Number: |  |
| Incorporating Legislation (e.g. ASIC, ORIC etc.) |
| Incorporation Date: |  |
| Details of the nominated Contact Person for this application: |
| Name: |  |
| Position: |  |
| Phone Number: |  |
| Email: |  |
| Name of the ACCHS that is supporting this application: |
| Please describe the type of health related services your Organisation provides: |
| The following documents are attached to this application:* Your Organisation’s Rule Book or Constitution.
* A signed copy of the Minutes of the meeting of the Managing Committee passing a resolution to apply for Full/Associate Membership of AHCWA.
* A copy of your Organisation’s Incorporation Certificate.
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**Declaration**

This section must be completed by the Chairperson of the Organisation seeking Membership.

I <insert Name> confirm that <Name of the Organisation> is seeking Membership of AHCWA.

I have read the Membership criteria and state that:

Our Organisation falls into one of the categories of Membership contained within the meaning of Schedule 1 (Dictionary) of the AHCWA Constitution.

**Aboriginal Community Controlled Health Service** means a legal entity that:

(a) through the operation of its governing document, requires at least 75% of its Members to be Aboriginal and/or Torres Strait Islander people;

(b) through the operation of its governing document, requires at least 75% of its Directors (or equivalent) to be Aboriginal and/or Torres Strait Islander people; and

(c) delivers Comprehensive Primary Health Care in the State of Western Australia to the community that controls it.

**Aboriginal Community Health Related Organisation** means a legal entity that:

(a) has Directors (or equivalent) that are elected by Members;

(b) requires in its governing document that a majority of its Members be Aboriginal and/or Torres Strait Islander people;

(c) requires in its governing document that the majority of its Directors (or equivalent) be Aboriginal and/or Torres Strait Islander people;

(d) has a majority of its Members residing within the region in which it provides services;

(e) provides Aboriginal Health Related Services in the State of Western Australia; and

(f) has rules in its governing document that prevent the distribution of funds to its Members and Directors (or equivalent).

**Aboriginal Health Relates Services**means a service:

(a) provided by an Aboriginal Community Controlled Health Service; or

(b) provided by an Aboriginal Community Controlled Health Related Organisation that:

 (i) is a specialty service or specialty services (which may include the provision of maternal and child health services, alcohol and other drug services, disease prevention services, men’s or women’s health services, aged and disability services, mental health services and dental services); and

 (ii) is delivered in pursuance of the achievement of Aboriginal health.

**Associate Member** means a Member admitted into Membership as an Associate Member in accordance with Rule 4.2(a).

**Ordinary Member** means a Member admitted into Membership as an Ordinary Member in accordance with Rule 4.2(a).

**Signatures Page:**

We acknowledge that the AHCWA Board has the authority to assess the relevant eligibility criteria and determine if the Organisation meets **Ordinary** or **Associate Membership.**

Signed by the **Chairperson** and **Director** of the Organisation seeking Full Membership.

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Signature of Chairperson Signature of Director

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Print Name Print Name

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Signature of Witness Signature of Witness

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Name of Witness Name of Witness

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This section to be filled out by the **Chairperson** and **Director** of the **ACCHS (within the region or nearest possible ACCHS)** supporting this application:

**Name off Current AHCWA Ordinary Member Service:**

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Signature of Chairperson Signature of Director

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Print Name Print Name

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Witness Signature of Witness

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Name of Witness Name of Witness

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_