



GUMALA ABORIGINAL CORPORATION

7.0

CRITICALLY ILL PATIENT SUPPORT

Registration Form

NAME:

_____ (Name of Member applying for funds)

ADDRESS:

DOB:

___ / ___ / ___

MOBILE:

HOME:

FAX:

EMAIL:

Language Group:

Banyjima

Innawonga

Nyiyaparli

DETAILS OF CIPS PATIENT:

FULL Name: _____

Is the CIPS patient a:

Member

Non Member

Child

Your relationship to patient: _____

DETAILS OF CURRENT ILLNESS: *(attach documentation e.g. Letter from Health Professional, etc)*

Have you received help or contributions towards costs?

YES

NO

(If yes, please provide details e.g. From: DCD, IBN, MIB, Personal contributions, etc and how much)

Family members authorised to access funds on my behalf :

(Please note: The below must be Gumala Members)

Name: _____	Phone: _____
Name: _____	Phone: _____
Name: _____	Phone: _____

Signature: _____

Date: _____

Forward completed applications to:

Fax: 08 9188 1846

Email:

gac@gumala.com.au

Office Use Only

Date received: _____

By: _____

Comments: _____

Date processed: _____

By: _____

Comments: _____