SHOALHAVEN PHOTOGRAPHIC CLUB MEMBERSHIP FORM

YEAR …….

NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____ **MOBILE:** _____

EMAIL: _____

SPOUSE/PARTNER'S NAME: _____

MEMBERSHIP FEES: **12 months: $25** ☐ **6 months or less: $15** ☐

AMOUNT PAID: $_____

I consent to receive emails and newsletters from the committee.

Phone: ☐ **Email:** ☐

Cash ☐ **Cheque** ☐ **Direct Deposit** ☐

Signed: _____ **Date:** _____

Receipt Number (Office Use): _____

Fees may be paid by direct deposit:

BANK ACCOUNT DETAILS

Account Name: Shoalhaven Photographic Club

BSB: 062 585, Account Number: 00910649

NOTE: Please use your family name & first initial as a reference when paying fees by direct deposit