MEDICAL TRAVEL ASSISTANCE APPLICATION FORM

FIRST NAME: _____

MIDDLE NAME: _____

SURNAME: _____

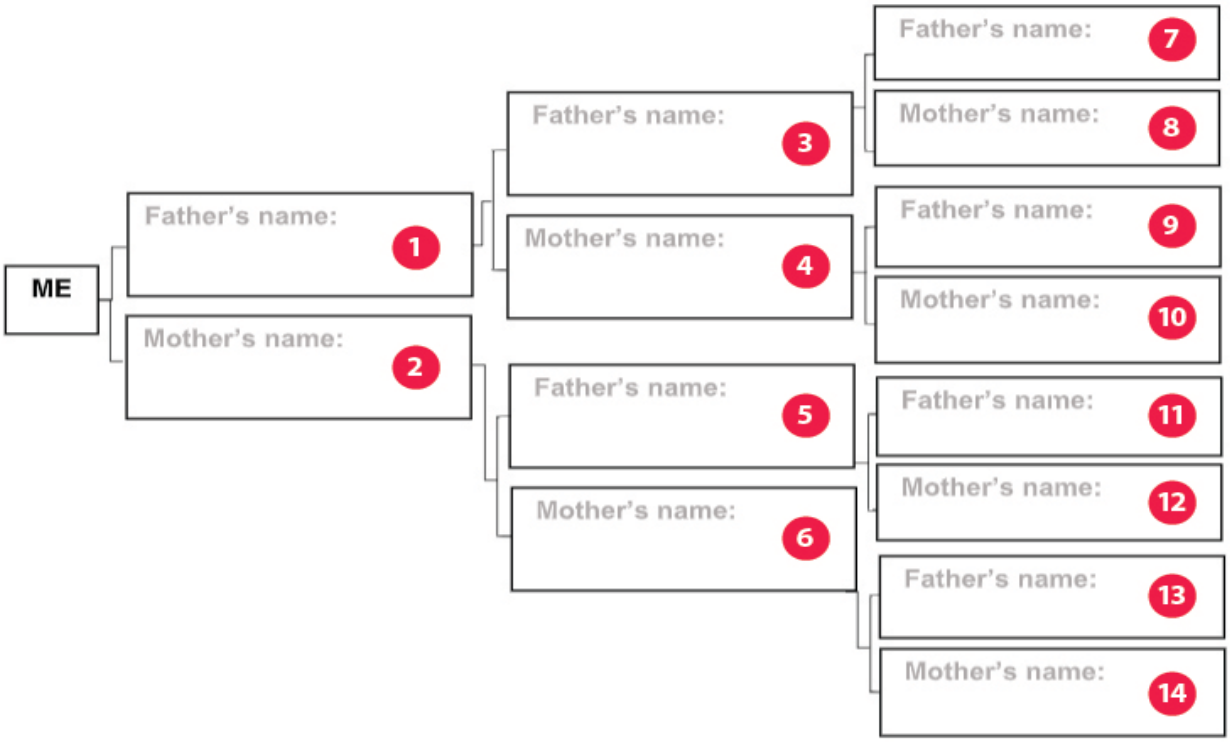
DATE OF BIRTH: _____

ADDRESS: _____

EMAIL: _____ MOBILE: _____

MEDICAL CRISIS TRAVEL $330_____ CHRONIC MEDICAL TRAVEL $125_____

NAME OF PERSON RECEIVING TREATMENT	YOUR RELATIONSHIP TO THIS PERSON



Please Note:

On approval of application a registered Gift Card will be issued to the applicant for the use of **Travel, Accommodation, Fuel and Food ONLY**. All cards are registered to the WCO and monitored by us. By signing below, you acknowledge that you understand the card will only be used for the above purposes and if **ANY inappropriate use of the Gift Card is recorded it will result in the applicant losing access to all funding assistance for twelve months.**

Application Declaration – I have read and understand the Policy and I declare all information supplied to be true and correct.

Signature: _____ *Date:* _____

For any application enquiries please contact the office on 08 9997 3444 or email members@wajarri.com.au

Meenangu Wajarri Aboriginal Corporation (ICN 7878)

Engaging, empowering and investing in Wajarri Yamatji People's future