

MEDICAL TRAVEL ASSISTANCE FUND APPLICATION FORM



FIRST NAME: _____

MIDDLE NAME: _____

SURNAME: _____

DATE OF BIRTH: _____

STREET: _____

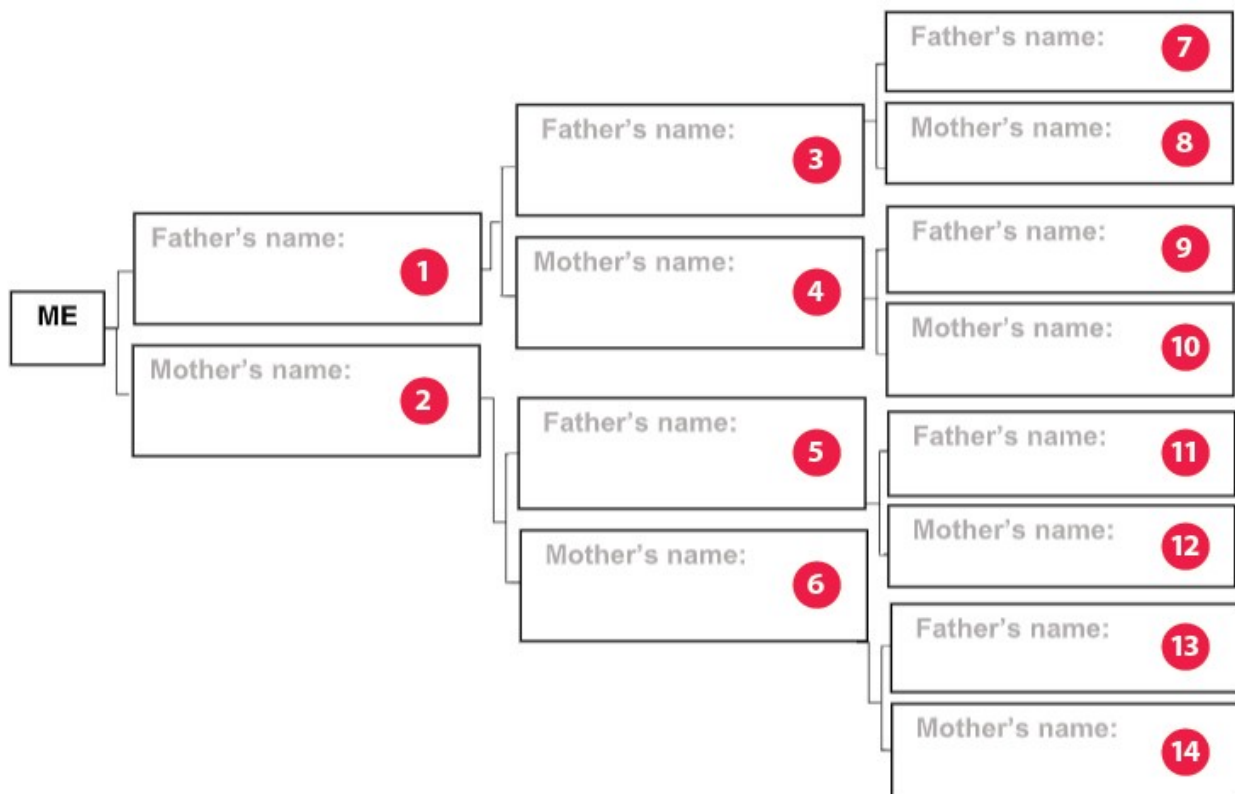
SUBURB: _____ POSTCODE: _____

EMAIL: _____

MOBILE: _____

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

NAME OF PERSON RECEIVING TREATMENT	YOUR RELATIONSHIP TO THIS PERSON



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

Wajarri Yamaji Aboriginal Corporation (ICN 7878)
Engaging, empowering and investing in Wajarri Yamaji People's future

MEDICAL TRAVEL ASSISTANCE FUND APPLICATION FORM



MASTERCARD DISCLAIMER

On approval of Medical Travel Assistance Fund application, a registered Mastercard 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 Mastercard 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: _____