

Soldiers & Sirens Ltd

Membership Application



To the Secretary
Soldiers & Sirens Ltd

Dear Secretary,

I hereby apply under clause 12 of the Constitution to become a member of Soldiers & Sirens Ltd (ACN: 63350493) and (ABN: 23633504935) and pay the annual membership fee. I support the purposes of the company as stated here:

- Providing mental health and wellbeing services to current and ex-serving military and first responders who suffer from, or are at risk of suffering from a psychological injury or condition;
- Referring current and ex-serving military and first responders who suffer from, or are at risk of suffering from a psychological injury or condition to appropriate medical professionals, where appropriate;
- Providing advice on mental health and wellbeing to current and ex-serving military and first responders and their immediate families;
- Support, carry out and publish the results of independent research into the prevention, prevalence, detection, management and treatment of psychological injuries or conditions among current and ex-serving military and first responders;
- By educating current and ex-serving military and first responders and their families to enable them to prevent, recognise, address and manage psychological injuries or conditions;
- By working collaboratively with other organisations where opportunities arise, to further our purposes.

I agree to comply with the company's constitution, including paying the guarantee under Clause 4, if required as shown below: -

4. The guarantee

Each member must contribute an amount not more than \$10 (the guarantee) to the property of the **company** if the **company** is wound up while the member is a member, or within 12 months after they stop being a member, and this contribution is required to pay for the:

- (a) debts and liabilities of the **company** incurred before the member stopped being a member, or
- (b) costs of winding up.

Please tick all that apply:

Former/serving Military Police Fire Services Ambulance/Paramedic
 Family member of the above Health General Supporter

PLEASE COMPLETE BELOW IN FULL

First Name: _____ Surname: _____

Address (for notices): _____

Suburb: _____ Post Code: _____

Telephone Number: _____

Email: _____

Signature: _____ Date: _____

OFFICE USE ONLY: Date Received: _____ Date Approved by Board: _____