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## Eyes For Africa Membership Form

NAME: \_\_\_\_\_  
(Title) (Surname) (Given Name/s)

POSTAL ADDRESS: \_\_\_\_\_

STATE: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

PHONE: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

MOBILE: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

Do you wish to receive the newsletter by email?  Yes  No

### Membership costs

- Please Tick  \$50 Adult Membership  
 \$100 2 x Adults Membership  
 \$25 Pensioner/Student

### Membership payment options

- Please Tick  Cash  
 Cheque  
 Credit Card (please fill in the slip below)

Send membership form and address cheque to:  
Eyes for Africa Charitable Foundation  
c/o Membership  
P.O. Box 87  
Mernda VIC 3754

I agree to abide by the foundation's rules (available from the Eyes for Africa web site)

Signature \_\_\_\_\_

For membership information please contact Caroline Ondracek, tel: 0407 306964;  
email [ctondracek@yahoo.com.au](mailto:ctondracek@yahoo.com.au)

### Credit card payment slip

(Please PRINT all details)

Please debit the following account in the amount of \$ \_\_\_\_\_

Please Tick  Visa Card  MasterCard

Card number: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Expiry Date: \_\_\_\_ / \_\_\_\_

Name of Cardholder: \_\_\_\_\_

Signature: \_\_\_\_\_

OFFICE USE ONLY Date Payment Received _____ Amount _____ Initials _____
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