OFFICE USE ONLY

PLEASE NOTE

(Access Password to Members Section of website may be issued at the discretion of the Executive)

UserName: _____

Password: _____

CHILD CARE CENTRES ASSOCIATION OF VICTORIA INC.

TAX INVOICE

ABN: 61 953 934 130

ASSOCIATE MEMBERSHIP APPLICATION

Valid for 12 Months from date of receipt or until opening of centre in which case the Associate Membership lapses and is replaced by Full Membership. Fee paid is credited against Full Membership Fee.

Please Complete the Following Details:

(1) Name: Mr./ Mrs./ Miss./ Ms: _____
Qualifications: _____
Private Address: _____
Private Telephone Number: _____ Business Telephone Number: _____
Fax Number: _____ Email Address: _____
Please Provide a Brief Outline of Associated Interests: _____

Please Complete the Following Details if Known: *(if applicable)*

(2) Name of Proposed Centre: _____
Address of Proposed Centre: _____
No. of Places of Proposed Centre: _____
Telephone Number of Proposed Centre: _____
Comments: _____

Signature: _____ Date: _____

Associate Membership Fee: $286.00 (10% GST Included)

Payment Method:

☐ ***Cheque payable to CCCAV*** ☐ ***EFT*** Details on request ☐ ***Mastercard*** ☐ ***Visa*** ***Expiry Date:*** ____/____

Cardholder's Name: _____ ***Signature:*** _____

Card No: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ***Auth. No:*** _____ ***Date:*** _____

Please complete and return to the Association at the address below - **Retain a copy for your *records*!**

CHILD CARE CENTRES ASSOCIATION OF VICTORIA INC. A0019539M
Suite 6, 539 Highett Road, Highett Victoria 3190 Phone (03) 9532 2017 Facsimile: (03) 9532 3336
Website: http://www.cccav.org.au Email: info@cccav.org.au

PLEASE NOTE!! THIS BECOMES A TAX INVOICE ON RECEIPT OF PAYMENT
PLEASE RETAIN A COPY FOR YOUR RECORDS