



Incorporation Act No. A0011390R

e-mail info@anaa.org.au
www.anaa.org.au

ACOUSTIC NEUROMA ASSOCIATION AUSTRALIA Inc.

MEMBERSHIP APPLICATION FORM

NAME: _____
(Given name) (Surname)

ADDRESS: _____
State Postcode

TELEPHONE: Home: _____ Mob: _____

EMAIL Address: (please print clearly) _____ @ _____

DATE OF BIRTH ____/____/____ Current Occupation: _____

Past Occupations: _____

Hobbies/Interests _____

Membership may include an additional family member for the one annual fee.

Additional Family Member Name: _____

Relationship: _____ Occupation: _____

Do you wish to have contact with other AN Members? Yes or No (please circle)

I agree to support the purposes and constitutional rules of the Acoustic Neuroma Association of Australasia.

SIGNED: _____ DATE: ____/____/____

How did you hear about the ANAA? _____

ANNUAL MEMBERSHIP FEES: \$25.00 (cheques or money orders payable to ANAA)

Please return this form and fee to:

Ms Heather Thompson
14 The Esplanade
Research
Victoria 3095

Or if using Direct Payment complete details below:

Account Name: ANAA Inc. (Commonwealth Bank)
BSB: 063-494 Account No: 1003 8011
Please state your name in reference when Paying
Directly.

All donations will be acknowledged by receipt and are tax deductible.

Office Use Only:

Contact person _____ Registered on member list _____ Receipt No. _____ Date Receipt Written _____

The following information is collected for statistical data only.

All personal data is held in strict confidence.

MEDICAL INFORMATION

DIAGNOSIS DETAILS:

Month and Year first diagnosed: _____

Who diagnosed you and what was their medical speciality?

Which side is your Acoustic Neuroma? Left or Right (please circle) Date of last MRI? _____
Size at last MRI? _____ (in mm)

Have you undergone any treatment? Yes or No (please circle)

If yes, please provide details: _____

Where were treated and by whom? _____

Do you currently experience any of the following:

Facial Nerve Damage: _____

Hearing Loss: _____

Balance Problems: _____

Eye Problems: _____

Headaches: _____

Altered Taste: _____

Memory Issues: _____

Other: _____

Have you undertaken any further treatment for any of the above issues? _____

Any other comments: _____
