**Why should I join**

**Grampians *dis*Ability Advocacy Association?**

You will be a member of an organisation that is committed to promoting quality of life, human rights and self-advocacy for all people with a disability.

This association is run by a volunteer Board of Governance, made up of people with a disability and community members.

**Our Motto:** “Our Choice, Our Voice.”

**Our Mission:** This advocacy service listens to, takes direction from, and stands beside people with disability, from the Central Highlands to across the Wimmera, in their interactions with organisations and the community.

We help people to learn about and act on their rights to achieve the best possible result.

**TYPES OF MEMBERSHIP**

**Full member:**

This is for any person who has an interest in or a lived experience of disability. Full members have one vote at any meeting of the Association. These members are able to nominate for a role on the Association’s Board of Governance.

**Associate member:**

Any person who does not meet the requirements of full membership or who does not want to have voting rights. This membership is also for Organisations wishing to be members. Associate members have no voting rights.

**MEMBERSHIP BENEFITS**

* Individual members can be on the Board of Governance
* Individual members can vote at meetings
* Members can attend all general meetings
* All members are able to attend GdA events and functions
* A free printed copy of our Quarterly newsletter
* Membership is FREE

**CONTACT US**

Grampians disAbility Advocacy

**Mail:** PO Box 112, Ararat, 3377

**Phone:** 1800 552 272

**Email**: admin@grampiansadvocacy.org.au

**Website:** www.grampiansadvocacy.org.au

MEMBERSHIP APPLICATION FORM

I would like to become a member of Grampians disAbility Advocacy Association (GdA). I support the Mission, Values and Goals of the Association as shown in the Annual Report and available on the GdA website. I agree to comply with the GdA Rules of Association.

I understand that my membership will need to be approved by the Board of Governance. Once approved the membership will be valid for three (3) years. After the three (3) years, I will be contacted about renewing my membership.

**MY CONTACT DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME |  | | | |
| ADDRESS |  | | | |
| PHONE NUMBER |  | | | |
| EMAIL ADDRESS |  | | | |
| DO YOU HAVE A DISABILITY? | YES |  | NO |  |

**EMERGENCY OR SUPPORT PERSON CONTACT DETAILS (optional)**

|  |  |
| --- | --- |
| NAME |  |
| PHONE NUMBER |  |
| EMAIL ADDRESS |  |
| RELATIONSHIP | **TYPE OF MEMBERSHIP YOU ARE APPLYING FOR** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **FULL MEMBERSHIP**   * Lived experience or an interest in disability * Membership has voting rights   **GET INVOLVED** |  | **ASSOCIATE MEMBERSHIP**   * Organisation or individual * Membership has NO voting rights | | | |  | |
| Do you want us to contact you about being on the Board of Governance? | | | YES |  | NO | |  |
| Would you like to be contacted about being on an advisory group or committee? | | | YES |  | NO | |  |

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

Applicant, Support Person, Parent or Advocate (please circle)

OFFICE USE ONLY:

Date received: Processed:

Membership Status: Full membership: Associate Membership:

OFFICE USE ONLY:

Date received: Processed:

Membership Status: Full membership: Associate Membership: