APPLICATION FOR MEMBERSHIP

Katherine West Health Board Aboriginal Corporation

I,

_____

(first name of applicant) *(last name of applicant)*

Date of Birth

of

_____

(address of applicant)

hereby apply for membership of Katherine West Health Board Aboriginal Corporation
(name of corporation)

I am Aboriginal or non-Aboriginal.

(Cross out whichever is not relevant)

I declare that I am eligible for membership.

Signed: _____

Date: _____