

OAS MEMBERSHIP APPLICATION

1	Member's Name:	_____
2	Salutation:	Mr/Mrs/Ms/Mdm _____
3	Date of Birth:	_____
4	Last 3 digits and letter of NRIC/FIN No. (e.g. 123A):	_____
5	Type of Surgery:	Ileostomy/Colostomy/Urostomy/No Stoma/Others, please specify: _____
6	Date of Surgery:	_____
7	Name of Hospital:	_____
8	Residential Address:	_____ _____ _____ _____
9	Nationality:	Singapore Citizen/Singapore PR/ Malaysian/Others, please specify: _____
10	Gender:	Male/Female _____
11	Marital Status:	Single/Married/Divorced/Separated/Widowed _____
12	Race:	Chinese/Malay/Indian/Others, please specify: _____ _____
13	Dialect group:	_____ _____
14	Religion:	_____ _____
15	Email Address:	_____ _____
16	Mobile Phone No:	_____ _____
17	Home Tel No:	_____ _____
18	Highest Educational Qualification:	_____ _____
19	Present Employment Status:	Self-Employed/ Employed Full Time/ Employed Part Time/ Unemployed/ Retired _____
	Name of Employer/ Company:	_____ _____
	Address:	_____ _____ _____ _____
	Position:	_____ _____
	Office Tel No.	_____ _____

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20 Please state membership in other registered societies. If not applicable, please state 'NA'.

Title of Office held	Full Name of Society

21 Preferred Mode of Contact: Email/Mobile Phone

By signing this form, I consent to receiving information from time to time from the Ostomy Association of Singapore regarding its activities, programmes and requests for updates of members' particulars.

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Date:	Signature:
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