THE NURSES' MEMORIAL FOUNDATION OF SOUTH AUSTRALIA LIMITED

APPLICATION FORM FOR FINANCIAL ASSISTANCE IN TIMES OF ILLNESS OR ADVERISTY

NURSES' MEMORIAL FOUNDATION OF SOUTH AUSTRALIA LIMITED
18 DEQUETTEVILLE TERRACE,
KENT TOWN, SA, 5067

APPLICANT (Title, Surname, Given names)

CONTACT DETAILS

(Address, Phone, email)

I AM / WAS A REGISTERED NURSE or REGISTERED MIDWIFE or ENROLLED NURSE (delete as necessary)

CURRENTLY EMPLOYED

(Name, address, contact)

Or

I RETIRED ON (DATE):

MY LAST PLACE OF EMPLOYMENT WAS:

DETAILS OF ASSISTANCE SOUGHT:

COSTS $ **RECEIPTS ATTACHED? YES/NO**

THIS APPLICATION IS SUPPORTED BY (Name of Health Professional):

of:

STATUTORY DECLARATION:

I HEREBY CERTIFY THAT THE STATEMENTS ABOVE ARE TRUE.

SIGNED:

BEFORE ME: JUSTICE OF THE PEACE

DATED:

MAIL TO: THE SECRETARY: NURSES' MEMORIAL FOUNDATION OF SOUTH AUSTRALIA LIMITED, 18 DEQUETTEVILLE TERRACE, KENT TOWN, SA, 5067