



REI ACT

REAL ESTATE INSTITUTE
OF THE AUSTRALIAN CAPITAL TERRITORY

APPLICATION FOR ASSOCIATE MEMBERSHIP

APPLICANT'S DETAILS

Name of Company, Organisation, Department or Individual

.....

ACN/ABN:

Nominated Person (if not an Individual):

INDIVIDUAL'S DETAILS

Surname Mr /Mrs/Miss/Ms:.....

Given Names:.....

Preferred Name:.....

Your Residential Address:.....

..... Postcode.....

Home Phone:..... Mobile:.....

Email:.....

Preferred Mailing Address: Business Home

Preferred Form of Contact: Mobile Email Post Fax

BUSINESS PARTICULARS

Nature of Business/Employment

.....

Relationship to the real estate industry:

Street Address:

..... Postcode

Postal Address:

..... Postcode

Phone: Fax:

Email:

Website:

CONTACT DETAILS – FOR COMMUNICATIONS, PUBLICATIONS, ACCOUNTS

Preferred Mailing Address:
.....Postcode
Phone: Fax:
Email:

DECLARATION

I/We declare that the statements set out above are true. I/We undertake to be bound by the Real Estate Institute of ACT (REIACT) Constitution and By-Laws, the Code of Conduct and any rules and regulations. The undersigned hereby certifies that he or she has authority to sign this form.

.....
Name Signature

Dated this.....day of.....

PRIVACY STATEMENT

REIACT is bound by the *Privacy Act 1988* and respects your right to privacy. The personal information you have provided on this form may be used to contact you with information on new products, services and industry events, or simply to participate in member surveys. If a member would like further information about privacy, or to access, update or correct their personal information, they may contact the REIACT on (02) 6282 4544, or email to admin@reiaact.com.au.

FEES

Associate \$550.00 (GST incl)

TAX INVOICE: This form becomes a Tax Invoice upon payment. Please retain a copy for your taxation records.

Payment Options

Cheque (Please make cheque payable to REIACT)

Please charge my credit card for \$.....

Visa

Mastercard

American Express

Credit Card Number ____ / ____ / ____ / ____ Expiry date __ / __

Cardholders Name:.....

Cardholders Signature:.....

Please return application form and payment to
REIACT Membership
PO Box 22
DEAKIN WEST ACT 2600
or
Tel (02) 6282 4544 Fax to 6285 1960

OFFICE USE ONLY

| | |
|-------------|--|
| Receipt No. | |
| Member No. | |
| Issued By | |

| | |
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| Date | |
| Valid to | |
| Web Access | |