DASSA Community Partnership Program

**Membership Form**

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| --- | --- | --- | --- | --- |
| **Full Name:** |  | | | |
| **Preferred Name:** |  | | **Preferred Pronoun:** |  |
| **Gender Identity:** | Female  Male  Nonbinary  Other: | | | |
| **Address:** |  | | | |
| **Phone:** |  | **Email:** |  | |
| **I identify as:** | Aboriginal  Torres Strait Islander  Both  Neither | | | |
| **Cultural Background:** |  | | | |
| **Languages spoken:** |  | | | |
| **I identify as part of the LGBTIQA+ community:** | Yes  No  Prefer not to answer | | | |

***Please note****: All information provided in this Membership Form will be kept strictly confidential and stored in a secure file. Your personal information will only be used for the purposes as requested and will not be distributed to third parties except where required by law. Our privacy policy can be obtained by emailing* [*Health.DASSACPP@sa.gov.au*](mailto:Health.DASSACPP@sa.gov.au)

|  |  |  |
| --- | --- | --- |
| **I would like to join the Community Network of DASSA’s Community Partnership Program to:**  *(mark all that apply)* | | |
| receive Newsletters  be informed  provide feedback / consultation  have short-term partnership opportunities  have longer-term partnership opportunities as a Community Representative  *This involves mandatory requirements and a recruitment process when opportunities arise* | | |
| I am / have been: | A client of drug and alcohol treatment services  Which services?  A carer (family/friend/support person) of someone who was / is misusing substances  A worker in a related field | |
| Anything else you would like to share with us: | |  |

Signature: Date:

***Thank you for joining, we look forward to working with you as part of our Community Network***

Please return your completed Membership Form to:

Coordinator Community Partnership Program

DASSA

91 Magill Road

Stepney SA 5069

[HealthDASSACPP@sa.gov.au](mailto:HealthDASSACPP@sa.gov.au)