The Pharmacy Guild of Australia
WA Branch

OFFICE USE ONLY
PYMT ID 1 _____
PYMT ID 2 _____

Pharmacy Guild of Australia (WA Branch) Direct Debit Request - Membership

Your Details | All fields are mandatory

Customer Number: ABN:

Pharmacy Name:

Surname: Given name:

Pharmacy Address:

Suburb: State: Postcode:

E-mail: Phone:

I/we request and authorise Pharmacy Guild of Australia, WA Branch, (APCA ID 600667) (ABN 56 917 919 584) to arrange, through its own financial institution, a debit to your nominated account through the Bulk Electronic Clearing System (BECS), or credit card, any amount, Pharmacy Guild of Australia WA Branch (APCA ID 600667) has deemed payable by you.

Signatory 1 | All fields are mandatory

Surname: Given name:

Pharmacy Address:

Suburb: State: Postcode:

Signature:

Date: 1 / 1 / 25

Signatory 2 | (if applicable)

Surname: Given name:

Pharmacy Address:

Suburb: State: Postcode:

Signature:

Date: 1 / 1 / 25

1322 Hay St, West Perth 6005, Telephone: (08) 9429 4100 Fax: (08) 9324 2075
Email: accounts@wa.guild.org.au website: www.guild.org.au

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Debit Arrangement | All fields are mandatory

Frequency: ☐ Monthly ☐ Quarterly ☐ Annually

Initial debit starting as set out in the Payment Instalments Option and schedule form 2025/2026.

Initial debit will be made from your nominated account on the 1 July 2025, and further payments will be made on the 28th of the month. This Direct Debit Request will remain in force until you advise the Pharmacy Guild of Australia, WA Branch (APCA ID 600667) that you wish to cancel your authorisation. Cancellation must be in writing, providing your full name and membership number. It is also advisable to notify your bank/building society/credit union.

Your Payment Method | Please choose one of the following payment methods. This section is to be completed by the account or card holder only.

1 Debit from Credit Card or Debit Card: ☐ Visa ☐ Mastercard

Card Number:

Expiry Date: 1 / 25

Name of Cardholder:

By signing this form, I/we authorise the Pharmacy Guild of Australia WA Branch to debit payments from my specified Credit Card above, and I/ we acknowledge having read and understood the terms and conditions governing the debit arrangements between the Pharmacy Guild of Australia WA Branch and I/us, as set out in this direct debit request and Direct Debit Request Service Agreement.

Cardholder's signature: Date: 1 / 25

2 Debit from Bank Account

Financial Institution: Branch:

BSB Number: Account Number:

Account Holders Name:

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