



MEMBERSHIP APPLICATION FORM
October 2011 to September 2012

Membership fees are currently \$33.00 (GST inclusive) for the year.
Do not send your payment with this form – an invoice will be sent to you.

I hereby apply for Full Membership of the Division

First Name: _____ Surname: _____ Preferred Name: _____
 Position Title: _____
 Business Name: _____
 Business Postal Address: _____
 Town: _____ State: _____ Postcode: _____
 Street Address: _____
 Work Phone: _____ Fax Number: _____
 Mobile Phone: _____ Email Address: _____

Note: Your personal details are for the internal use of the Division and will not be disclosed to a third party.

GP Members Only: D.O.B. _____ Graduation (MBBS) Yr _____ Place _____
 Medical Qualifications: _____
 CPD No. (RACGP) _____ CME No. (ACRRM) _____
 Special Clinical Interests: _____

Allied Health/Specialists only:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Aboriginal Health Worker | <input type="checkbox"/> Endocrinologist | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Researcher |
| <input type="checkbox"/> Aged Care Worker | <input type="checkbox"/> Exercise Physiologist | <input type="checkbox"/> Physician – General | <input type="checkbox"/> Retired GP |
| <input type="checkbox"/> Anaesthetist | <input type="checkbox"/> Health Service Admin | <input type="checkbox"/> Physician – Occupational | <input type="checkbox"/> Retired Specialist |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Intern | <input type="checkbox"/> Physician – Renal | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Mental Health Worker | <input type="checkbox"/> Physician – Respiratory | <input type="checkbox"/> Sonographer |
| <input type="checkbox"/> Clinical Geneticist | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Physician – Sleep | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> Clinical Haematologist | <input type="checkbox"/> Nurse | <input type="checkbox"/> Physiotherapist | <input type="checkbox"/> Surgeon - Breast |
| <input type="checkbox"/> Cosmetic Medicine | <input type="checkbox"/> Obstetrics/Gynaecology | <input type="checkbox"/> Podiatrist | <input type="checkbox"/> Surgeon – General |
| <input type="checkbox"/> Counsellor | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Practice Manager | <input type="checkbox"/> Surgeon – Hand & Wrist |
| <input type="checkbox"/> Dermatologist | <input type="checkbox"/> Oncologist | <input type="checkbox"/> Practice Nurse | <input type="checkbox"/> Surgeon – Oral |
| <input type="checkbox"/> Diabetes Educator | <input type="checkbox"/> Ophthalmologist | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Surgeon – Orthopaedic |
| <input type="checkbox"/> Dietitian | <input type="checkbox"/> Orthotics/Prosthetics | <input type="checkbox"/> Psychologist | <input type="checkbox"/> Surgeon – Plastic/Recon |
| <input type="checkbox"/> Drug & Alcohol | <input type="checkbox"/> Paediatrician | <input type="checkbox"/> Radiation Oncologist | <input type="checkbox"/> Surgeon – Vascular |
| <input type="checkbox"/> Ear, Nose & Throat | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Radiologist | <input type="checkbox"/> Urologist |
| <input type="checkbox"/> ED Doctor | <input type="checkbox"/> Pathologist | <input type="checkbox"/> Registrar | <input type="checkbox"/> Weightloss/Lifestyle |
| <input type="checkbox"/> Other – please specify: _____ | | | |

Office Use Only: AF23 Chilli Chilli Date: _____ Invoice # _____ Invoice Date: _____

Please forward this completed form to PO Box 2244, BUNBURY WA 6231 or Fax to 08 9791 5111