



# Application for Associate Membership

Australian College of Rural and Remote Medicine

2011—2012

## Categories and fees *(Part-year is calculated pro rata to 30 June 2012: one-twelfth per month)*

**Organisation: \$1,305.00**

Your organisation has a strong interest in rural and remote medicine or health

**Health professional: \$90.00**

You are an allied health professional, practice manager, or health administrator

**Student: \$11.00 *(no pro rata)***

You are enrolled in an undergraduate or graduate course in medicine or health

## Membership category

Corporate

Individual

Student. I participate in:

John Flynn Placement Program

Bonded Medical Placement Scheme

Medical Rural Bonded Placement Scheme

None of the above

## Identity

Title: \_\_\_\_\_ First name: \_\_\_\_\_ Other name/s: \_\_\_\_\_

Family name: \_\_\_\_\_ Preferred name: \_\_\_\_\_

Date of birth: DD/MM/YYYY

Gender:  Female  
 Male

I am  Aboriginal  
 Torres Strait Islander

## Private contact details \*

Street address: \_\_\_\_\_ Town or Suburb: \_\_\_\_\_

State: \_\_\_\_\_ Postcode: \_\_\_\_\_ Country: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## Organisation/university contacts \*

Organisation/university: \_\_\_\_\_

Street address: \_\_\_\_\_ Town or Suburb: \_\_\_\_\_

State: \_\_\_\_\_ Postcode: \_\_\_\_\_ Country: \_\_\_\_\_ Fax: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

\* For correspondence, I prefer the College uses my  Org/Uni contacts  Private contacts [please tick one]

## Declaration

I declare that the information on this form is, to the best of my knowledge, complete and correct. I acknowledge that my membership to ACRRM is bound by the policies and procedures of the College. As a member I shall uphold the Objects of ACRRM and abide by the Regulations and the Code of Professional Ethics and Conduct which requires me to observe the highest standards of clinical, professional and ethical behaviour in all of my activities.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## Privacy:

I understand ACRRM collects and stores my personal information for the purposes of providing membership services, and education and training programs. Personal information will not be passed onto any other external bodies without my authorisation, unless a valid legal request is received.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**TO PAY: please see over...**

