

APPLICATION FOR MEMBERSHIP

(Sections marked with * are compulsory)

*MEMBERSHIP CATEGORY APPLIED FOR: (Please tick one box only)			
<input type="checkbox"/> FULL MEMBERSHIP		<input type="checkbox"/> ASSOCIATE MEMBERSHIP	
PERSONAL DETAILS			
*Title:	*Surname:		*First Names:
Telephone:		Fax:	Mobile No: [For Division Records only]
Email:			
*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth:	
PROFESSIONAL DETAILS			
*PROFESSIONAL STATUS	ALL APPLICANTS TO COMPLETE QUALIFICATION DETAILS <input type="checkbox"/> Registrar <input type="checkbox"/> International Medical Graduate (IMG) <input type="checkbox"/> Practice Nurse <input type="checkbox"/> Locum <input type="checkbox"/> Full GP <input type="checkbox"/> Practice Manager		
*Qualifications: Degree/Diploma/Certificate:			
*Name of Institution / University / Examining Body:			
*Date and year conferred:		*Country where qualified:	
*Prescriber No:		*Provider No:	
QA/RACGP No:		ACRRM No:	
Specific Skills /Special interests:			
PRACTICE DETAILS (<i>this is the address for posted and delivered correspondence</i>)			
*PRIMARY PRACTICE NAME:			START DATE:
Street:		Suburb:	
State:	Postcode:	Telephone:	Fax:
Practice Email Address:			
OTHER PRACTICES			
ALTERNATIVE CONTACT ADDRESS (<i>e.g. Home address</i>)			
Street:			
Suburb:		Postcode:	
Telephone:		Fax:	
*SIGNATURE	X		*DATE
*PROPOSED BY:			*Prescriber No:
Please forward the completed application form to:		OFFICE USE ONLY	
Sunshine Coast Division of General Practice Ltd PO Box 389 Cotton Tree Qld 4558 or Fax 5456 8899		Registration No:	Received:
		Approved:	Archived:
		Processed:	Reinstated: