

Associate Membership Application Form

ABN: 83 604 341 559

More information on RMSANZ membership can be found at: <http://www.rmsanz.net>

NEW APPLICATION TO JOIN

Title: _____ **First Name:** _____ **Surname:** _____

Position: _____

Preferred Postal Address: _____

Post Code: _____

Preferred Email: _____

Phone: (work hours) _____

Mobile: _____

How would you describe your current role?

- Non FAFRM Medical Practitioner or Scientist
- Registered Nurse
- Physiotherapist
- Occupational Therapist
- Clinical Psychologist or Neuropsychologist
- Speech / Language Pathologist
- Social Worker
- Orthotist or Prosthetist
- Dietitian
- Other _____

NOMINATION FOR ASSOCIATE MEMBERSHIP

The following RMSANZ Group (Branch or Special Interest Group) has nominated me for membership:

Name of Group _____

Name & signature of office bearer from nominating Group _____

OR

The following two Directors have nominated me for membership:

Name & signature of Director _____

Name & signature of Director _____

ASSOCIATE MEMBERSHIP FEES *(Applicable for the period of one year from 1 July to 30 June)*

\$200.00 AUD Associate Membership (GST Inclusive)

DONATIONS

If you would like to support the RMSANZ by making a donation, please complete the following, and include the additional amount when paying your membership fees.

I wish to make a donation of \$ _____ to RMSANZ.

PAYMENT METHODS

Total amount being paid: \$ _____

- Direct Deposit Details – Westpac Account for **RMSANZ Ltd** BSB: 032621 Account No: 553800
Please record your name in the “Message/Reference” field of your Internet Banking site.
- Cheque (Please make cheque out to **RMSANZ Ltd.** & post to the address below)
- Credit card (Please complete the detachable payment slip on Page 3 of this form)

APPLICANT DECLARATION

The RMSANZ Constitution May 2016 is available at: <http://www.rmsanz.net>

I confirm that I have read the Constitution of the Rehabilitation Medicine Society of Australia and New Zealand Ltd (RMSANZ) dated May 2016 and that, as a Member of RMSANZ, I agree to be bound by that Constitution and any of its related By-Laws which may apply from time to time. I acknowledge Clause 3.1.1 with the understanding that being granted membership of the RMSANZ does not grant any right or qualification to practice Rehabilitation Medicine or any other kind of medicine and I shall not hold myself out as having such right or qualification by virtue of that membership. I will abide by and uphold the Objects of the Constitution as set out in Clause 2.3 in a manner which promotes the professionalism and integrity of Rehabilitation Medicine practice.

I understand that RMSANZ is a not-for-profit company limited by guarantee and that my guarantee is limited to twenty dollars (AUD \$20.00).

I certify that I meet the eligibility criteria for the membership category applied for on this form and that I will immediately advise RMSANZ of any change in eligibility.

I also certify that I am a current financial member of my respective professional association or relevant specialist medical college.

I hereby authorise my name to be placed in the Register of Members.

Signature _____

Date _____

Complete this form, sign, scan, save & email to the RMSANZ Administrative Officer at admin@rmsanz.net

OR

post to: RMSANZ Administrative Officer, P.O. Box 637, North Sydney NSW 2059

RECEIPT / INVOICE

This document will become your **RECEIPT / INVOICE** when completed & payment is made in full so please keep a copy for your records.

PRIVACY DISCLAIMER

The collection of these details is primarily so that we can register you as a member of RMSANZ. This information will be stored in the RMSANZ database and may be used for future marketing of RMSANZ events. As a service to its members the RMSANZ will provide your name and business contact details ONLY to other members of the RMSANZ upon request. If you do not wish your details to be made available, please tick this box . If you do not tick the box, then RMSANZ will consider that the individuals completing this form consent to their personal details being used in the manner indicated.

Credit Card Payment Slip	Please attach to applicable forms or applications
<i>Please use this slip instead of adding information to the applications provided by the RMSANZ Ltd. We are dedicated to protecting your privacy. We destroy this slip after processing and keep the original application on file. Thank you!</i>	
<i>Questions? Phone: 0414992324 or email: admin@rmsanz.net</i>	

Select Card	Payment For (Member Name & Number, Event Name, etc.)	Total Paid (AUD)
<input type="checkbox"/> Visa	Card Holder Name	Contact Phone or Email
<input type="checkbox"/> MasterCard	Card Billing Address	
	Card Number	
	Expiry Date	CCV Code

Additional Notes Regarding This Payment:
