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 from 1 September 2017 to the end of June 2018)*

☐ $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.

Rehabilitation Medicine Society of Australia & New Zealand Ltd
P.O. Box 777
Cairns QLD 4870

Contact: RMSANZ Administrative Officer
Email: admin@rmsanz.net
Website: www.rmsanz.net

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 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 2017/2018 Register of Members.

Signature _____

Date _____

Complete this form, sign, scan, save & email to:

Sybil Cumming (RMSANZ Administrator) at admin@rmsanz.net

OR

complete, sign and post to: RMSANZ Administrative Officer, P.O. Box 777, Cairns, QLD 4870

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.

RMSANZ

Credit Card Payment Slip	Please attach to applicable forms or applications

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!*
Questions? Phone: 0414992324 or email: admin@rmsanz.net

Select Card	Payment For *(Member Name & Number, Event Name, etc.)*	Total Paid (AUD)
☐ Visa ☐ MasterCard	**Card Holder Name**	**Contact Phone or Email**
	Card Billing Address	
	Card Number	
	Expiry Date	**CCV Code**

Additional Notes Regarding This Payment:

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