



AUSTRALIAN ASSOCIATION OF CONSULTANT PHYSICIANS

2010 AACP Membership Application

1 January – 31 December

To: The Secretary, Australian Association of Consultant Physicians

I wish to become a Member of the Australian Association of Consultant Physicians (AACP) and agree to abide by the Memorandum and Articles of Association of the AACP.

PERSONAL DETAILS

PLEASE USE BLOCK LETTERS

TITLE:	DATE OF BIRTH: / /	GENDER: <input type="checkbox"/> M <input type="checkbox"/> F
FIRST NAME:	MIDDLE NAME:	
SURNAME:		

CONTACT INFORMATION

EMAIL:		
ADDRESS:		
SUBURB:	STATE:	POSTCODE:
☎ WORK: (0)	FAX: (0)	
MOBILE:		

SURVEY QUESTIONS

QUALIFICATIONS:	
MAIN SPECIALTY:	SPECIALITY SOCIETY: (MAIN ONE ONLY)
AMA MEMBER: <input type="checkbox"/> Yes <input type="checkbox"/> No	ARE YOU IN PRIVATE PRACTICE: <input type="checkbox"/> Yes <input type="checkbox"/> No

SIGNED: _____ DATED: _____

PAYMENT METHODS	<input type="checkbox"/> ONLINE * (PayPal)	<input type="checkbox"/> CREDIT CARD	<input type="checkbox"/> CHEQUE *
	www.consultantphysicians.com.au	FAX: 02 9555 1383	PO Box 145, Balmain NSW 2041

CARD TYPE: Amex Diners MasterCard Visa tick (✓)

NAME ON CARD: _____

CARD NUMBER: _____ / _____ / _____ / _____

EXPIRY DATE: ____ / ____

TOTAL: **\$295.00** (INC \$26.82 GST)

SIGNATURE: _____

DATE: _____

* Online: Also return completed form to AACP * Cheques: Make payable to 'The Australian Association of Consultant Physicians Ltd'

THIS DOCUMENT BECOMES A TAX INVOICE ON PAYMENT - Keep a copy for your records

Office Use Only: OL

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