



AUSTRALIAN ASSOCIATION OF CONSULTANT PHYSICIANS

2012 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: M F

FIRST NAME: _____ MIDDLE NAME: _____

SURNAME: _____

CONTACT DETAILS

EMAIL: _____

ADDRESS: _____

SUBURB: _____ STATE: _____ POSTCODE: _____

☎ WORK: (0) _____ FAX: (0) _____

MOBILE: _____

PROFESSIONAL INFORMATION

Qualifications: _____

Main Specialty: _____ Specialty Society: (main one only) _____

Are you an AMA member: Yes No Are you in private practice: Yes No

Have you been an AACP member before: Yes No

SIGNED: _____ DATED: _____

PAYMENT METHODS

ONLINE
www.consultantphysicians.com.au/join
Please also send completed form to AACP

CHEQUE
MAIL: PO Box 145, Balmain NSW 2041
Payable to "The Australian Association of Consultant Physicians Ltd"

CREDIT CARD
FAX: 02 9555 1383 MAIL: PO Box 145, Balmain NSW 2041

CARD TYPE: NAME ON CARD: _____
 Amex CARD NUMBER: _____ / _____ / _____ EXP ____ / ____
 Diners SIGNATURE: _____ AMOUNT: **\$295.00 (including \$26.82 GST)**
 MasterCard
 Visa Please retain my credit card details for automatic annual renewal of my membership.

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

Office Use Only: OL