

Application for Associate Membership

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE



Membership Fees

Health Professional: \$135

IMG Associate: \$180

Student: \$30

Identity

Title: _____ First Name: _____ Middle Name: _____

Last Name: _____ Date of Birth: _____

Gender: Male Female I am: Aboriginal Torres Strait Islander

Contact Details

Street Address: _____ Town or Suburb: _____

State: _____ Postcode: _____ Country: _____ Phone: _____

Mobile: _____ Fax: _____ Email: _____

Student Details

University where currently enrolled: _____

Qualification being studied: _____

I am in year: _____ Student Number: _____ Graduation Date: _____

Declaration

I declare that the information on this form is, to the best of my knowledge, complete and correct. I acknowledge that my membership to ACRRM is bound by the policies and procedures of the College. As a member I shall uphold the Objects of ACRRM and abide by the Regulations and the Code of Professional Ethics and Conduct which requires me to observe the highest standards of clinical, professional and ethical behavior in all of my activities.

Signed: _____ Date: _____

Privacy

I understand Australian College of Rural and Remote Medicine ("the College") collects, stores and discloses my personal information for the purposes of providing membership products and services, for training programs, for maintaining my membership records, for research or statistical purposes and to promote services which the College considers may be of interest to me. This information may be collected directly from me in my dealings with the College.

To fulfil the purposes set out above, my personal information may also be collected from or passed onto external bodies which usually includes medical colleges, government organisations and associated training providers, or as otherwise permitted or required by law.

Further information about the collection of personal information is available here in the College's Privacy Policy. The Privacy Policy contains information about how you may access and seek correction of your personal information and how you can complain about a breach of the Australian Privacy Principles. <https://www.acrrm.org.au/privacy>

Signed: _____ Date: _____

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Payment Methods

- Mail**
Complete this form and mail it with your payment to:
ACRRM
GPO Box 2507
Brisbane QLD 4001
- Fax**
Complete and fax this form with credit card details to ACRRM on (07) 3105 8299
- Direct Deposit**
Write your full name in the reference field.
- Phone**
Freecall 1800 223 226 and have your Visa or MasterCard Details ready.

How to Pay

Direct Deposit

Account name: ACRRM
BSB: 034 003
Account number: 264 808
Reference: (Enter your full name)

Cheque or Money Order

Please make payable to:
Australian College of Rural and Remote Medicine

Credit Card

Please debit my Visa Mastercard

Amount: AUD \$.

Number:

Expiry Date: M M Y Y

Card holders name: _____ Signature _____