Application for
Ordinary Membership

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

Membership Category

☐ General Practice ☐ Specialist Practitioner ☐ Academic Specialty: _____

Membership level *(For explanations, please see panel below)*

☐ Full Time ☐ Registar ☐ Resident or Intern ☐ IMG on Specialist Pathway

☐ Part Time ☐ Joint (Couples) ☐ International ☐ Retired/Extended Leave

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: _____

Medical Registration

Medical Registration Number: _____

Membership Fees

Full Time: $1190 Joint (couples): $935 each Part time: $720 Group Practice: $1090

Registrar: $410 Resident or Int: $65 International: $470 Extended Leave & Retired by Request

Qualifications

Primary Medical Qualifications

Date	Qualification	Institution	Country

Other Medical Qualifications

Date	Qualification	Institution	Country

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: _____

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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, governmentorganisations 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: _____

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 _____