



ABN: 37 062 388 130

MEMBERSHIP APPLICATION FORM

Title: _____ First name: _____ Surname: _____

Membership Policies, Benefits and conditions

- In the event of me becoming a member of the Mid North Coast (NSW) Division of General Practice, I agree to be bound by provisions of the Memorandum and Articles of Association of the Company including any variations to those provisions that may be made from time to time.
- I have read understood and agree to the Mid North Coast (NSW) Division of General Practice membership policies, benefits and conditions at www.mncdgp.org.au

Date: _____ Signature: _____

Membership Fees 2010/2011

- GP Membership (free)
- Associate Membership \$150 (GST inclusive)

Referring Member

This application must be proposed and signed by a full member of the Mid North Coast Division of General Practice.

Name of the referring Member _____

Signature: _____ Date: _____

How would you like to receive the Division's Annual Report?

- By Post (hard copy sent to your nominated address)
- Access it yourself from Division Website at www.mncdgp.org.au

Definitions of Division Membership Categories:

- **Full Member** - A Registered General Medical Practitioner whose practice involves the provision of primary, continuing and comprehensive whole-patient care for at least one session per week, including practitioners providing GP services to targeted groups (e.g. ATSI, Women), may apply in writing to the Company for admission as a **Full Member** of the Company.
- **Associate Member** - Allied Health, Other medical practitioners, GP registrars, locums and medical students may apply in writing to the Company for admission as an **Associate Member** of the Company.
- **Life Member** - A retired General Medical Practitioner may be awarded, at the discretion of the Board, admission as a **Life Member** of the Company.

Eligibility for Membership

Eligibility for membership is restricted to persons who work within the geographic area of the Mid North Coast (NSW) Division of General Practice and reside within the same boundaries or adjacent Division of General Practice boundaries.

Please fill in the details (overleaf) of the membership-type that applies to you.

Approved By CEO:

Full-Member (GP):

Title:	First name:	Surname:
Gender: M / F	Date of Birth:	Country of Birth:
Practice Name:		
Preferred Postal Address:		
Telephone:	Fax:	
Business Email:		
QA & CPD Number:		
ACCRM or RACGP:		
Provider Number:	Prescriber Number:	
ABN:	Are you registered to collect GST? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Graduating University:	
Degrees, diplomas, awards:	
Languages (other than English) spoken fluently:	
Hospital Appointments:	
Memberships of Medical organisations (eg. RACGP, AAGP, AMA, PDA, DRS):	
Are you Vocationally Registered: (Recognised as a specialist GP by the RACGP).	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, please indicate if your medical registration is: <input type="checkbox"/> Full Registration <input type="checkbox"/> Conditional Registration
If not Vocationally Registered are you?	<input type="checkbox"/> Overseas trained doctor in an "Area of Need Position" <input type="checkbox"/> Temporary Resident Doctor <input type="checkbox"/> Registrar (RACGP) <input type="checkbox"/> OMP (Other Medical Practitioner) <input type="checkbox"/> Other (Specify)
Which option most accurately describes your primary working situation?	<input type="checkbox"/> Resident GP <input type="checkbox"/> GP Locum <input type="checkbox"/> Registrar <input type="checkbox"/> On leave (e.g. maternity, study) Type of leave _____ <input type="checkbox"/> Other Specify
Do you work as a GP Representative/Delegate? If yes, how many hours per week:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your Practice host Medical Students?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you teach or supervise? If yes, how many hours per week:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total hours worked per week?	
Do you see Aboriginal Patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Which computer hardware/software do you currently use at your practice?	

Associate Member (Registrars, Allied Health, Students & Others):

Are you eligible for the Medicare Criteria for team care arrangements? Yes No

- Allied Health – Speciality Area: _____
- Pharmacist
- Practice Nurse
- Specialist/Consultant
- Registrar/Student
- Other - please specify: _____

Title:	First name:	Surname:
Gender: M / F	Date of Birth:	
Practice Name:		
Preferred Postal Address:		
Telephone:	Fax:	
Business Email:		
Affiliated Body:		
Provider Number:	Prescriber Number:	
Current Registration Number:		
ABN:	Are you registered to collect GST? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Graduating University:	
Degrees, diplomas, awards:	
Languages (other than English) spoken fluently:	
Do you teach or supervise? If yes, how many hours per week:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Which computer hardware / software do you currently use at your practice?	
Do you currently practice in any of the following areas?	<input type="checkbox"/> Obstetrics <input type="checkbox"/> Surgery <input type="checkbox"/> Anaesthetics <input type="checkbox"/> Radiology

SECTION 1

Your Areas of Interest:

- Mental Health
- Child and Youth Health
- Aged Care
- Emergency Medicine
- Indigenous Health
- Ante-natal Care
- Mens / Womens Health
- Musculo Skeletal
- Refugee Health
- Research
- Community Health
- Oral Health
- Other _____

SECTION 2

Five subject areas you wish to be provided as an education topic:

Topic 1: _____

Topic 2: _____

Topic 3: _____

Topic 4: _____

Topic 5: _____