



**AAMSA**

Australian Association of Medical Surgical Assistants

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Arncliffe NSW 2205  
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Email: [info@aamsa.org.au](mailto:info@aamsa.org.au)  
Web: [www.aamsa.org.au](http://www.aamsa.org.au)  
ABN 86 076 781 747

# Application for Membership

## *Personal and Professional Details*

**Successful applicants will be invoiced \$300.00 pa (GST free) for 12 months membership (or part thereof)**

I, being the applicant named on this application for membership, desire to become a Member of the Australian Association of Medical Surgical Assistants Incorporated ABN 86 076 781 747 (an association incorporated in NSW) and hereby agree, if admitted to membership, to be bound by the Memorandum and Articles of Association of the Australian Association of Medical Surgical Assistants Incorporated for the time being in force and hereby authorise my name to be placed in the Register of Members.

Name \_\_\_\_\_

Address \_\_\_\_\_

Suburb / Town \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Telephone (w) \_\_\_\_\_ (h) \_\_\_\_\_

Facsimile (w) \_\_\_\_\_ (h) \_\_\_\_\_

Mobile \_\_\_\_\_

E-mail \_\_\_\_\_

Specialty \_\_\_\_\_

Professional Qualifications \_\_\_\_\_

\_\_\_\_\_

Principal hospitals I am accredited to:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Professional medical organisations I belong to:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your membership must be nominated and seconded by two financial Members of the Australian Association of Medical Surgical Assistants Incorporated and/or 2 medical practitioners unconditionally registered by the appropriate State Medical Board in the Commonwealth of Australia (henceforth known as a qualified medical practitioner).

**NOMINATOR:**

Name \_\_\_\_\_

Address \_\_\_\_\_

As a qualified medical practitioner, I nominate the applicant, who is personally known to me.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**SECONDER:**

Name \_\_\_\_\_

Address \_\_\_\_\_

As a qualified medical practitioner, I second the nomination of the applicant, who is personally known to me.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**APPLICANT:**

I acknowledge that I am a medical practitioner licensed to practice by my State Medical Board and I accept the Terms and Conditions of Membership which are available to me on application from AAMSA, PO Box 12, Arncliffe, NSW 2205

**APPLICANT FOR MEMBERSHIP SIGNS HERE**

Signature \_\_\_\_\_

Date \_\_\_\_\_

## Application for Membership

### *Remittance Advice*

ABN 86 076 781 747

Please accept my payment for membership of the Australian Association of Medical Surgical Assistants Incorporated, the details of which I have indicated below.

#### Membership Category

A detailed explanation of each membership category can be found in the Terms and Conditions of Membership, which are available to me upon request.

The category of membership I am applying for is:

**Ordinary Member:** \$300.00 per annum

#### **Payment Type – please tick one of the options below:**

##### *Payment by Cheque*

- Please find enclosed my cheque for \$300.00 being one year's annual membership fee.

OR

##### *Payment by Credit Card*

Please debit my credit card for \$300.00, being one year's annual membership fee.

- American Express  
 Diners Club  
 Mastercard  
 Visa

Card No. \_\_\_\_\_

Name on Card \_\_\_\_\_

Signature \_\_\_\_\_

Expiry Date \_\_\_\_\_

When both the Personal & Professional Details and Remittance Advice sections have been completed please return this application together with your payment to:

**Australian Association of Medical Surgical Assistants Inc.  
PO Box 12  
Arncliffe, NSW, 2205  
Australia.**