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AACMA

APPLICATION # ____ / ____

ID # _____

APPLICATION FOR MEMBERSHIP

This form is intended for practitioners and others who have qualified to practise.
Students who have not yet qualified should complete the Application for Student Membership form.

PERSONAL DETAILS		
TITLE Prof Dr Mr Ms Mrs Miss Other	FAMILY NAME	GIVEN NAMES
POSTAL ADDRESS (Incl State & Postcode)		
HOME ADDRESS (Incl State & Postcode)		
HOME PHONE	FAX	MOBILE
DATE OF BIRTH dd/mm/yyyy	PLACE OF BIRTH (Town and Country)	
EMAIL ADDRESS		
CITIZEN/ PERMANENT RESIDENT OF <input type="checkbox"/> Australia OR <input type="checkbox"/> Other (please state)		
NAME, AS YOU WOULD LIKE IT TO APPEAR ON CERTIFICATES (No titles or business names)		

PRACTICE DETAILS		
CLINIC 1 ADDRESS (Incl State & Postcode)		
CLINIC PHONE	FAX	WEBSITE
CLINIC 2 ADDRESS (Incl State & Postcode)		
CLINIC PHONE	FAX	WEBSITE
CLINIC 3 ADDRESS (Incl State & Postcode)		
CLINIC PHONE	FAX	WEBSITE

OTHER DETAILS	
ENGLISH LANGUAGE PROFICIENCY	My first language is <input type="checkbox"/> English OR <input type="checkbox"/> a language other than English, please specify _____
If your first language is a language other than English, please complete →	My English language proficiency level is _____ Attach a certified copy of any English language proficiency tests e.g. IELTS or ASLPR tests.
ETHICAL PRACTICE (You must complete this section)	<input type="checkbox"/> I HAVE NOT been deregistered or suspended by a health professions registration board and I HAVE NOT been suspended or expelled from a professional association for breach of the Code of Ethics or the Constitution/Rules of the Association. <input type="checkbox"/> I HAVE been deregistered or suspended by a health professions registration board OR I HAVE been suspended or expelled from a professional association for breach of the Code of Ethics or the Constitution/Rules of the Association.. Please provide details on an attached sheet.

Signature of applicant

Date signed (DD/MM/YYYY)

PRACTICE EXPERIENCE
I have practised or completed my studies within the last 2 years. <input type="checkbox"/> YES <input type="checkbox"/> NO – when were you last in clinical practice?

