Personal Details

Surname: ______________________

Given names: ______________________

Date of Birth: ______________ male / female

Business Contact Details:

Hospital: ______________________

or

Practice Name: ______________________

Address: ______________________

____

Ph: __________ Fax: __________

Email: ______________________

Home Contact Details:

Address: ______________________

____

Ph: __________ Fax: __________

Mobile: ______________________

Email: ______________________

Preferred Mailing Address: ❍ Home ❍ Practice/Business

Joint Member Discount

Joint membership is available for spouses (25% off the normal fee for each member). IF choosing this option, please specify:

Partners Name: ______________________

Member Number: ______________________

Correspondence to be sent to: ☐ yourself ☐ your partner

PRIVACY: The Privacy Act 1988 and the National Privacy Principles apply to the AMA(SA). The AMA(SA) collects personal information for the purposes of processing applications for membership, maintaining membership records and contacting members. If you wish to make a complaint or inquiry regarding your personal information you can do so by sending an email to admin@amasa.org.au or by writing or faxing to the Privacy Officer at the AMA(SA).

Special Interest Groups

Please select a Special Interest Group from below

- ❍ General Practitioners
- ❍ Surgeons
- ❍ Obstetricians & Gynaecologists
- ❍ Salaried Doctors
- ❍ Emergency Physicians
- ❍ Orthopaedic Surgeons
- ❍ Doctors in Training

  ………. Year after graduation
- ❍ Physicians
- ❍ Psychiatrists
- ❍ Pathologists
- ❍ Anaesthetists
- ❍ Radiologists
- ❍ Paediatricians
- ❍ Dermatologists

Type of Practice

Private Practice

☐ General Practitioner

☐ Specialist (Specialty: ______________)

Salaried Medical Officer

☐ Specialist (Specialty: ______________)

☐ With Private Practice Rights

☐ RMO

☐ Registrar (Field ______________)

Other

☐ Part-time in Practice (number of sessions worked ______)

☐ Permanently Retired

☐ Over 70 in Practice

☐ Academic/Postgraduate/Not practicing

☐ Other (Please Specify ______________)

Other Details — Qualifications

Languages spoken: ______________________

Initial Qualifications: ______________________

Institution: ______________________

Higher Qualifications: ______________________

Institution: ______________________

Payment Details

(Please tick one)

Please select from the enclosed schedule:

Membership Category: ______________________

Annual Subscription Amount: ______________________

Donation/s: ______________________

Total Payable: ______________________

Please indicate your preferred option of payment:

❍ **Payment by Cheque**

Cheques should be made payable to Australian Medical Association (SA) for the appropriate fee

❍ **Payment by Credit Card**

❍ AMEX ❍ Diners ❍ Visa ❍ MasterCard

Card Number: ______________________

Expiry Date: ______/_____ Amount : $ ....

____

Name of cardholder

____

Signature of cardholder

Monthly Direct Debit Request

❍ **Payment by Credit Card** (to be debited each month)

❍ AMEX ❍ Diners ❍ Visa ❍ MasterCard

Card Number: ______________________

Expiry Date: ______/_____ Amount : $ ....

To be debited each month

____

Name of cardholder

____

Signature of cardholder

AMA(SA) Membership Application

Monthly Direct Debit Request

Please select from the enclosed schedule:

By signing this document,

I/We: ____

Surname Given Names

authorise The Australian Medical Association (South Australia) Inc, ABN 91 028 693 268, Debit User Number 007997, the Debit User, to debit my/our account, detailed in the Schedule below, with any amount, through the Direct Debit System. I/We must pay when due under the arrangement between us.

This authority is to remain in force until further notice.

____

Signature

Date ………../…………/………..

❍ **Payment by Monthly Direct Debit Bank Details**

Financial Institution Name: ____________________

Address: ____________________

____

Account Name: ____________________

BSB Number: __________ - __________

Account Number: ____________________

Donations

I would like to make a donation to the

Medical Benevolent Association of $ ______________ *

Doctor's Health Advisory Service of $ ______________ *

(*Please include amount in total cheque or credit card payment)

Communications

Preferred communication method

How would you like to receive communication from us?

- ☐ Email
- ☐ Mail - Home address
- ☐ Mail - Business/practice address
- ☐ Fax

Publications

- medicSA
- Medical Journal of Australia
- Australian Medicine

Media Enquiries

Are you able to assist us with media enquiries?

☐ Yes ☐ No

Preferred provider materials

The AMA(SA) has arrangements with preferred providers that require use of the membership mailing list.

Please tick if you do not wish to receive preferred provider material. ☐

Benefits of Membership

- Subscription to the publications listed below:
  - *medicSA*
  - The Medical Journal of Australia
  - Australian Medicine
  - AMA List of Medical Services and Fees
- Information and advice on legal, financial and medical practice issues, including clerical awards, goodwill practice valuations, mediation and practice structures and agreements.
- Industrial representation and advice
- Information seminars and workshops on a wide range of topics
- A network of preferred providers offering preferential services to AMA members

Please send completed application form to:
Membership Coordinator, PO Box 134, North Adelaide SA 5006
or
fax to (08) 8267 5349

Declarations

Declaration

I agree, if elected, to observe the principles stated in the Declaration of Geneva printed below and to abide by:

- The Regulations and By-laws and to uphold the Code of Ethics of the Australian Medical Association for the time being in force.
- The Memorandum and Articles of Association and By-laws of the Australian Medical Association (South Australia).
- The requirements of any other Division or Branch of the Australian Medical Association to which I may at any time belong.
- Paying my annual subscription of the Association.

Declaration of Geneva

" I solemnly pledge to consecrate my life to the service of humanity;
I will give to my teachers the respect and gratitude that is their due;
I will practise my profession with conscience and dignity;
The health of my patient will by my first consideration;
I will respect the secrets that are confided in me, even after the patient has died;
I will maintain, by all the means in my power the honour and the noble traditions of the medical profession;
My colleagues will be my sisters and brothers;
I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
I will maintain the utmost respect for human life;
I will not use my medical knowledge to violate human rights and civil liberties, even under threat;
I make these promises solemnly, freely and upon my honour."

Signature ____

Date ……./……./…….

Introduced By: ____________________________(if relevant)