



# AMA Membership Application

## 1. PERSONAL DETAILS

Surname: .....

Given Names: .....

Date of Birth: .....Male/Female

### Contact Details:

Business/Practice Name: .....

Address: .....

Ph: .....Fax: .....

### Home Address:

.....

.....

Ph: .....Fax: .....

Mobile: .....

Email .....

Preferred Mailing Address:  Home  Practice/Business

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

Partner's Name: .....

Member No. ....

Correspondence to be sent to:  yourself  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](mailto:admin@amasa.org.au) or by writing or faxing to the Privacy Officer at the AMA(SA).

## 2. SPECIAL INTEREST GROUPS

Please select a Special Interest Group from below

- |   |  |
|---|--|
| <input type="checkbox"/> General Practitioners          | <input type="checkbox"/> Physicians    |
| <input type="checkbox"/> Surgeons & Ophthalmologists    | <input type="checkbox"/> Psychiatrists |
| <input type="checkbox"/> Obstetricians & Gynaecologists | <input type="checkbox"/> Pathologists  |
| <input type="checkbox"/> Full-Time Salaried             | <input type="checkbox"/> Anaesthetists |
| <input type="checkbox"/> Doctors in Training            | <input type="checkbox"/> Radiologists  |

## 3. TYPE OF PRACTICE

Please tick one

### 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

Initial Qualifications: .....

Name of School:.....

Higher Qualifications: .....

Name of School:.....

Languages other than English which you speak proficiently:

.....

**4. PAYMENT DETAILS**

Please select from the enclosed schedule of fees:

**Membership Category:**.....

Subscription Amount: .....

Please indicate your preferred option for payment:

**Payment by Cheque**

Please attach a cheque payable to the Australian Medical Association (South Australia) for the appropriate subscription fee

**Payment by Credit Card**

Please charge my:  AMEX  Diners  Visa  Mastercard  
Card Number:

□□□□ □□□□ □□□□ □□□□

Expiry Date: ..... /..... Amount : \$.....

.....  
Name of cardholder Signature of cardholder

**Payment by Monthly Direct Debit**

**Selected Bank Account**

Please complete the Direct Debit Request (DDR) and the Schedule overleaf. To download a copy of the DDR Service agreement, please access our website [www.amasa.org.au](http://www.amasa.org.au) and refer to the "membership apply" section.

**Credit Card**

Please charge my:  AMEX  Diners  Visa  Mastercard  
Card Number:

□□□□ □□□□ □□□□ □□□□

Expiry Date: ...../..... Amount : \$.....  
to be debited each month

.....  
Name of cardholder Signature of cardholder



**Direct Debit Request**

(NOTE: account must be a trading or savings account. Credit card accounts should be nominated on the other side of this form)

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 ...../...../.....

**The Schedule**

Financial Institution Name: .....

Address: .....

.....

Account Title: .....

BSB Number:    -

Account Number:

**DONATIONS**

I would like to make a donation to the:

**Medical Benevolent Association** of \$.....

**Doctors' Health Advisory Service** of \$.....

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



## 5. 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 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 this box if you do not wish to receive preferred provider material.

### **Benefits of Membership**

- Subscription to the following publications:
  - medicSA
  - The Medical Journal of Australia
  - Australian Medicine
  - AMA List of Medical Services & 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 relevant topics
- A network of preferred providers offering preferential services to AMA members

## 6. DECLARATIONS

### Declaration

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

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