



# ACRRM Registrar

Pathway Enrolment and Membership Application 2010-2011

Australian College of Rural and Remote Medicine

## My pathway

I have been accepted into the

- |  |
|--|
| <input type="checkbox"/> Remote Vocational Training Scheme (RVTS) pathway    |
| <input type="checkbox"/> Australian General Practice Training (AGPT) pathway |

The date I was accepted	<input type="text"/>	<input type="text"/>	<input type="text"/>
	DD	MM	YYYY

My Regional Training Provider	<input type="text"/>	Verified by ACRRM officer
-------------------------------	----------------------	---------------------------

I wish to enrol in the Australian College of Rural and Remote Medicine's **Vocational Training program** and to apply for **Registrar Membership** to train for Fellowship of ACRRM. I understand I must maintain current financial membership of ACRRM throughout my training.

## My identity

Title	<input type="text"/>	First Name	<input type="text"/>
Other name/s	<input type="text"/>	Preferred name	<input type="text"/>
Family Name	<input type="text"/>		

Date of birth    Gender  Female  Male I am  Aboriginal  Torres Strait Islander

DD MM YYYY

## Private contact details\*

Street	<input type="text"/>	Town/Suburb	<input type="text"/>
State	<input type="text"/>	Postcode	<input type="text"/>
Country	<input type="text"/>		
Phone	<input type="text"/>	Mobile	<input type="text"/>
Email	<input type="text"/>	Fax	<input type="text"/>

## Business contact details\*

Street	<input type="text"/>	Town/Suburb	<input type="text"/>
State	<input type="text"/>	Postcode	<input type="text"/>
Country	<input type="text"/>		
Phone	<input type="text"/>	Mobile	<input type="text"/>
Email	<input type="text"/>	Fax	<input type="text"/>

\*Please indicate which contacts you prefer the College to use

- Business Contacts  
 Private contacts

**Medical registration**

Medical registration number	
-----------------------------	--

Verified (by ACRRM officer)	
Signature:	Date:

**Medical qualifications**

Date	Qualification	Institution	Country

**How I would like to represent the College or participate in College activities (optional)**

I would like information about

- the ACRRM Registrar Committee
- mentoring a medical student
- participating in my area(s) of special interest (eg anaesthetics, obstetrics). Please nominate your areas of interest

--

**Declaration**

- The information on this form is, to the best of my knowledge, complete and correct. I acknowledge that my membership of ACRRM is bound by the policies and procedures of the College. As a member I shall uphold the Objects of ACRRM and abide by the Regulations and the Code of Professional Ethics and Conduct which require me to observe the highest standards of clinical, professional, and ethical behaviour in all my activities.

**Privacy and use of information**

- I understand that ACRRM will collect, store, and share the information I provide on this form for the purposes of providing membership services, and for reporting on my education and training programs. ACRRM shares information with medical boards, training providers, government health departments and authorities (such as GPET). ACRRM may be obliged to share information with other organisations if it receives a valid legal demand.
- I am employed by Queensland Health and authorise ACRRM to send this department information relevant to my training.

Signed ..... Date ...../...../.....

## Registrar Membership Fee—2010-2011

Membership fee: \$230 (full year)

**Pro-rata:** If you are joining after July 2010, your membership is calculated at \$20 per whole month remaining in that year.

### Payment methods

1. Mail	2. Fax	3. Phone	4. Direct deposit
Complete this form and mail it with your payment to ACRRM GPO Box 2507 Brisbane Qld 4001	Complete and fax this form (with credit card details) to ACRRM on (07) 3105 8299	Freecall <b>1800 223 226</b> . Please have your Visa or MasterCard details ready.	If paying by direct deposit, please write your full name in the reference field.

### How to pay

Direct deposit	Cheque or money order
<i>Account name</i> ACRRM <i>BSB</i> 034 003 <i>Account number</i> 264 808 <i>Reference</i> (Enter your full name)	Please make your cheque payable to <b>Australian College of Rural and Remote Medicine</b>

### Credit Card

Please debit my	<input type="checkbox"/> <b>Visa</b> <input type="checkbox"/> <b>MasterCard</b>			
Amount AUD \$				
Card number				
Expiry date	(MM)		(YY)	
Card holder's name				

Cardholder's signature.....

version 15-03-11