



OPTOMETRISTS
ASSOCIATION AUSTRALIA
QUEENSLAND & NORTHERN TERRITORY

APPLICATION FOR FULL MEMBERSHIP

Optometrist name in full: Mr/Mrs/Miss/Ms/Dr(please print) being an Optometrist duly registered under the provisions of The Optometrists Act 2001 do hereby apply for admission to membership of the Optometrists Association Australia, Queensland & Northern Territory Division Incorporated and do hereby agree, if elected, to adhere and to be bound by the Rules and By-Laws of the Association.

I also agree to pay in advance, the necessary fees as fixed from time to time by Council.
I certify that the attached information is correct.

I remit herewith the sum of \$.....to make me financial to 30 June next.

Signature of Applicant..... **Date:** / /

Name of Proposer

Signature of Proposer(Must be Full Member of Queensland/NT Div)

Address of Proposer

Name of Seconder(Must be Full Member of Queensland/NT Div)

Signature of Seconder

Address of Seconder

CATEGORIES OF MEMBERSHIP SUBSCRIPTION INCLUDING GST (PLEASE SELECT)

- | | | | |
|--|------------------|---|-----------------|
| <input type="checkbox"/> Ordinary Member (more than 12hrs per week) | \$1320.00 | <input type="checkbox"/> Academic Member | \$660.00 |
| <input type="checkbox"/> Non-Practising Member | \$ 333.00 | <input type="checkbox"/> Recent Graduate Member | \$660.00 |
| <input type="checkbox"/> Transfer from another Division | NIL | <input type="checkbox"/> New Graduate Member | NIL |
| <input type="checkbox"/> Minimal Practice Member (< 3 hrs per week) | \$ 440.00 | | |
| <input type="checkbox"/> Partial Practice Member (3-12 hrs per week) | \$ 660.00 | | |

PAYMENT DETAILS

My cheque is attached

OR please charge \$..... to my (PLEASE SELECT) MASTERCARD / VISA / AMEX number:

□□□□ □□□□ □□□□ □□□□ Expiry □□ / □□

Signed:..... Name:

PRIVACY POLICY

The personal information you have provided on this form may be used to contact you with information on new products, services and industry events, or simply to participate in member surveys. The vast majority of our members and non-member clients welcome this communication. However, in full recognition and respect of your privacy rights, we would like to confirm this with you.

Please be aware that you can update this advice at any time by contacting us.

Preferred method of contact:
 Mail Fax / Phone Email



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APPLICATION FOR FULL MEMBERSHIP

PERSONAL/PRACTICE INFORMATION (PLEASE COMPLETE)

Preferred Name:
Postal Address:

Phone:..... Fax:.....

Home Address:

Phone:..... Fax:..... Email:.....

Primary Practice: Business Name:
Address:
Phone:..... Fax:..... Email:.....

Type of Primary Practice: (PLEASE CIRCLE) Corporate / Private

Secondary Practice: Business Name:
Address:
Phone: Fax: Email:

Visiting Locations: Business Name & Address: Phone:
Business Name & Address: Phone:

Position: (PLEASE CIRCLE) Locum / Manager / Part – Joint Owner / Sole Owner / Salaried Employee

Date of Birth:/...../..... **Queensland / NT Optometrists Board Registration No.**

Previous Member of OAA? Yes [] No []

If **YES**, which State No. of Years: Member No.

QUALIFICATIONS

<u>Year Graduated</u>	<u>Institution:</u>	<u>Qualification / Degree</u>

OTHER

Involvement in VDU Screenings? Yes [] No []

Do you provide these visits? (PLEASE CIRCLE) Home / Hospital / Nursing Home

Suburbs/Area?

I am certified to use Diagnostic Drugs? Yes [] No [] **Course:**.....

I have completed an ocular therapeutics course and passed the examination: Yes [] No []

If **Yes**, what course:

Languages: in which you can conduct an optometric consultation: e.g. sign language, Japanese

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