

# AWGPN Application for Associateship Membership

PERSONAL DETAILS			
Surname			
Given name/s			
Email			
Phone (m)		Phone (h)	
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	
Occupation		CPD/QA Number	
Languages spoken			
Professional Qualifications & Memberships			

PRACTICE DETAILS			
Practice Name			
Address			
Suburb		State	Post code
Phone		Fax number	
Alt phone		Phone/fax?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Practice email			
Practice website			
Wheelchair access?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Home visits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Practice hours			

ASSOCIATESHIP NOMINATION			
Category <i>(please tick one)</i>	<input type="checkbox"/> GP Registrar/Trainee	<input type="checkbox"/> GP Practice Manager/Staff Member	<input type="checkbox"/> GP Practice Nurse
	<input type="checkbox"/> Allied Health Practitioner	<input type="checkbox"/> Mental Health Practitioner	<input type="checkbox"/> Other Primary Health Care Practitioner
	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Other Persons/Organisation <i>(please specify)</i>	
Nominated by	Name of GP Member		
	Signature	Date	
Seconded by	Name of GP Member		
	Signature	Date	

AGREEMENT		
<input type="checkbox"/>	I certify that I meet the criteria for Associate Membership	
<input type="checkbox"/>	I subscribe to the Objects and Purposes of the AWGPN and shall abide by the Rules of Incorporation (please see our website <a href="http://www.awgpn.org.au">www.awgpn.org.au</a> – path: about us>governance)	
Signature		Date

**Return Form To**

Membership Officer  
 Adelaide Western General Practice Network Inc  
 Locked Bag 13  
 Regency Park SA 5942  
 or by fax 08 8243 0260

**OFFICE USE ONLY**

--