



Associate Membership Form 2009 - 2010

Title: Prof / Dr / Mr / Mrs / Ms Surname: _____ First Name: _____

Age Range: ≤34 35-44 45-54 55-64 65+ (used for workforce planning)

Profession: Psychologist Pharmacist Physiotherapist Exercise Physiologist
 Other Primary Healthcare Providers only _____

Professional Registration Number: _____

Contact details:

Mailing Address: _____

Email Address: _____

Telephone/Mobile: _____

Fax Number: _____

Most preferred form of Contact

Mailing address Email Address Telephone/Mobile Fax

Practice/Workplace Details:

Name: _____

Address: _____

Telephone: _____ Fax: _____

Email: _____

Associate Membership \$55.00 (Incl GST)

I wish to pay by:

Cheque payable to Eastern Sydney Division of General Practice

MasterCard Card Number _____ Expire Date _____ / _____

Visa Cardholder's Name.....

Amex Cardholder's Signature.....

**Please forward membership form with cheque or credit card details (no cash) to:
Eastern Sydney Division of General Practice Ltd
Suite 103, Level 1, 35 Spring Street, Bondi Junction NSW 2022**

Signature:.....Date.....



Privacy Policy

The Information obtained will be used by the ESDGP in accordance with the privacy policy which can be found at www.esdgp.org.au