North Coast
Allied Health Association

MEMBERSHIP APPLICATION FORM

Membership Process

Applicants must complete a two-step process for Membership

1. **Complete the application form and email to:**

rfitzroy@ncphn.org.au

or mail to

North Coast Allied Health Association

PO Box 957

Ballina NSW 2478

2. **Complete payment of the annual membership subscription fee**

Online at http://ow.ly/Z0hQB

or

Send cheque to NCAHA with application form

or

Request an invoice

Membership Application

I wish to become an Ordinary/Associate Member of North Coast Allied Health Association NSW Limited, subject to the provisions of the Constitution.

Title			
Name			
Date of Birth			
Residential Address			
Postal Address	Same as above ☐		
Phone Number		Mobile Number	
Email Address			
Name of Primary Employer		Address of Primary Employer	
Discipline/Profession			
Qualifications*	***Provide AHPRA registration number or evidence of qualification (course name and place of study)**		
Class of Membership	Ordinary ☐ Associate ☐		

Membership Fee Payment

The annual fee, per financial year, is set at $40. Finalisation of your membership will be dependent on the full payment of the fee. (Applications received after March 2016 will be due for renewal 30 June 2017)

Method of payment *(Please tick your method of payment)*

☐ Online at http://ow.ly/Z0hQB
☐ Cheque made to NCAHA
☐ Invoice requested

Declaration

I declare that all information provided is true and accurate

Name

Date

NCAHA membership profile

Your answers are strictly confidential and aimed to support the work of NCAHA – you will not be individually identified in any results that are published or presented.

What best describes your current employment situation? *(Please tick appropriate box)*

Contractor		NGO employee		Public system employee	
Private system employee		Retired		Self-employed	
Student		Unemployed		Academic	
Not Practicing		Other			

Please specify 'Other' _____

What clinical setting do you mainly practice? *(Please tick appropriate box)*

Community Health		General Practice / Aboriginal Medical Service	
Hospital (seeing outpatients)		Hospital (seeing inpatients)	
Private clinic		Residential Aged Care	
Other			

Please specify 'Other' _____

Area of interest or clinical speciality *(Please specify)* _____

In what year did you qualify? *(Please specify)* _____

In what town/suburb do you work? *(Please specify)* _____

Number of years you have practiced in this region? *(Please specify)* _____

What is your country of birth? *(Please specify)* _____

Are you Aboriginal or Torres Strait Islander?

Yes		No	