North Coast
Allied Health Association

MEMBERSHIP APPLICATION FORM

Complete the application form and email to:

NCAHAExecutive@hotmail.com

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 currently set at $0.00.

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	