



## CHANGE OF STATUS MEMBERSHIP FORM 2010 / 11

Only complete this form if your membership category has changed.

Please return completed form to **PO Box 193 Surrey Hills VIC 3127** T: 03 9895 4463 F: 03 9898 0249 E:[office@orthoptics.org.au](mailto:office@orthoptics.org.au)

### Personal Details

<b>Title</b>	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	<input type="checkbox"/> Mrs	<input type="checkbox"/> Mr	<input type="checkbox"/> Dr	<input type="checkbox"/> A/Prof	<b>MOA</b>
<b>Given Name</b>				<b>Surname</b>			
<b>Maiden Name</b>				<b>DOB</b>	/	/	
<b>Home Address</b>							
<b>Suburb</b>				<b>Postcode</b>			<b>Country</b>
<b>Home Phone</b>	(0 )				<b>Work Phone</b>	(0 )	
<b>Mobile</b>				<b>Email*</b>			

\* Please note that the OA communicates extensively via email and that a current email address will ensure you are kept up to date with all announcements

### Membership Category

- Ordinary** - I hereby state that I am a graduate of an orthoptic course, recognised by the Association, or hold a certificate of registration with the Australian Orthoptic Board.
- Part Time** - I hereby state that I meet the criteria for ordinary membership, but that I am engaged in part time work which on average includes no more than eight (8) hours per week from an eye health related employment.
- Associate** - I hereby state that I am not engaged in eye health related employment in Australia.

### Membership Declaration

In applying for membership I declare that both the information and the supporting documentation I have provided are a true and accurate record and that I agree to be bound by the rules of the Association for the time being in force.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Select Membership Level (in AUS \$)

For more information regarding the membership levels, please visit the [Membership Fee Structure](http://www.orthoptics.org.au) section of the Association website [www.orthoptics.org.au](http://www.orthoptics.org.au)

### Federal Fee

- |                          |        |           |           |
|--------------------------|--------|-----------|-----------|
| <input type="checkbox"/> | Gold   | Ordinary  | \$ 368.00 |
| <input type="checkbox"/> | Gold   | Part-Time | \$ 220.00 |
| <input type="checkbox"/> | Gold   | Associate | \$ 147.00 |
| <input type="checkbox"/> | Silver | Ordinary  | \$ 423.00 |
| <input type="checkbox"/> | Silver | Part-Time | \$ 254.00 |
| <input type="checkbox"/> | Silver | Associate | \$ 169.00 |
| <input type="checkbox"/> | Bronze | Ordinary  | \$ 478.00 |
| <input type="checkbox"/> | Bronze | Part-Time | \$ 287.00 |
| <input type="checkbox"/> | Bronze | Associate | \$ 191.00 |

### NSW or VIC Branch Fees

(total amount below includes federal fee)

- |                          |        |           |           |
|--------------------------|--------|-----------|-----------|
| <input type="checkbox"/> | Gold   | Ordinary  | \$ 452.00 |
| <input type="checkbox"/> | Gold   | Part-Time | \$ 305.00 |
| <input type="checkbox"/> | Gold   | Associate | \$ 232.00 |
| <input type="checkbox"/> | Silver | Ordinary  | \$ 507.00 |
| <input type="checkbox"/> | Silver | Part-Time | \$ 338.00 |
| <input type="checkbox"/> | Silver | Associate | \$ 253.00 |
| <input type="checkbox"/> | Bronze | Ordinary  | \$ 562.00 |
| <input type="checkbox"/> | Bronze | Part-Time | \$ 371.00 |
| <input type="checkbox"/> | Bronze | Associate | \$ 275.00 |

NB: For Student and New Graduate Membership, please request or download the Student & New Graduate Application Form.

## Total Membership Fees

Total Amount Due \$ \_\_\_\_\_

## Payment Options

Credit Card

Card Type Visa  Master Card

Name on Card \_\_\_\_\_

Card No.

Expiry Date

Signed \_\_\_\_\_

Cheque

Please return the copy of this invoice with your cheque made payable to

**Orthoptics Australia**

PO Box 193 Surrey Hills, VIC, 3127

Direct transfer

Directly to our bank account:

**Orthoptics Australia**

**BSB: 032-376**

**Account No: 202176**

**Reference Code: Your Full Name (e.g. Joe Smith)**

## Checklist

- Provided an email address for communication
- Signed the Membership Declaration
- Completed details for the Member Directory

## Membership Details for Publication in OA Directory

<b>Given Name</b>		<b>Surname</b>	
<b>Mobile</b>		<b>Email</b>	
<b>Membership Category</b>	<input type="checkbox"/> Ordinary <input type="checkbox"/> Part-Time <input type="checkbox"/> Associate <input type="checkbox"/> Fellow <input type="checkbox"/> New Graduate <input type="checkbox"/> Student		
<b>Sub-Specialty Interest/s</b>			

## Workplace Details for Publication in OA Directory

Please complete one section for each place of employment using the below coding.

### Session Code

1 = am Monday      7 = am Thursday  
 2 = pm Monday      8 = pm Thursday  
 3 = am Tuesday      9 = am Friday  
 4 = pm Tuesday      10 = pm Friday  
 5 = am Wednesday    11 = am Saturday  
 6 = pm Wednesday    12 = pm Saturday

### Clinic Type Code

H = Hospital      LV = Low Vision Agency  
 P = Private Practice    M = Management  
 S = Self Employed      O = Other  
 E = Educational Institution  
 R = Research  
 CS = Community Screening  
 T = Clinical Placements Teaching

### WORKPLACE 1

<b>Session</b>		<b>Clinic Type</b>	
<b>Employer's Name</b> (Practice/Clinic/Institution)			
<b>Address</b>			
<b>State</b>		<b>Postcode</b>	
<b>Country</b>			
<b>Phone</b>	(0 )	<b>Fax</b>	

### WORKPLACE 2

<b>Session</b>		<b>Clinic Type</b>	
<b>Employer's Name</b> (Practice/Clinic/Institution)			
<b>Address</b>			
<b>State</b>		<b>Postcode</b>	
<b>Country</b>			
<b>Phone</b>	(0 )	<b>Fax</b>	

### WORKPLACE 3

<b>Session</b>		<b>Clinic Type</b>	
<b>Employer's Name</b> (Practice/Clinic/Institution)			
<b>Address</b>			
<b>State</b>		<b>Postcode</b>	
<b>Country</b>			
<b>Phone</b>	(0 )	<b>Fax</b>	

**WORKPLACE 4**

<b>Session</b>		<b>Clinic Type</b>	
<b>Employer's Name</b> (Practice/Clinic/Institution)			
<b>Address</b>			
<b>State</b>		<b>Postcode</b>	<b>Country</b>
<b>Phone</b>	(0 )	<b>Fax</b>	

**WORKPLACE 5**

<b>Session</b>		<b>Clinic Type</b>	
<b>Employer's Name</b> (Practice/Clinic/Institution)			
<b>Address</b>			
<b>State</b>		<b>Postcode</b>	<b>Country</b>
<b>Phone</b>	(0 )	<b>Fax</b>	