



MEMBERSHIP APPLICATION FORM 2011 / 12

Please return completed form to **PO Box 1104 Greythorn VIC 3104** T: 03 9857 9390 F: 03 9011 6237 E:office@orthoptics.org.au

Personal Details

Title	<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	MOA	
Given Name				Surname				
Maiden Name				DOB	/	/		
Home Address								
Suburb				Postcode			Country	
Home Phone	(0)				Work Phone	(0)		
Mobile				Email*				

Please confirm the State or Territory in Australia where you work _____

* 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

Qualification and Registration

Qualification(s)*				Institution			
Year of completion				AOB Reg No*			

* Please enclose a certified copy of your academic qualifications and/or a certified copy of registration with the AOB

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

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

(incl. Federal and State Fees)

- | | | |
|--------------------------|------------------|-----------|
| <input type="checkbox"/> | Gold Ordinary | \$ 452.00 |
| <input type="checkbox"/> | Gold Part-Time | \$ 304.00 |
| <input type="checkbox"/> | Gold Associate | \$ 231.00 |
| <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 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 1104 Greythorn, VIC, 3104

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 Certified Copies of Qualifications and/or AOB Registration
- Provided an email address for communication
- Signed the Membership Declaration
- Completed details for the Member Directory

Membership Details for Publication in OA Member Directory

Given Name		Surname	
Mobile		Email	
Membership Category	<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		
Sub-Specialty Interest/s			

Workplace Details for Publication in OA Member 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 CS = Casual Locum
 E = Educational Institution O = Other
 R = Research
 CS = Community Screening
 T = Clinical Placements Teaching

WORKPLACE 1

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

WORKPLACE 2

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

WORKPLACE 3

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

WORKPLACE 4

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

WORKPLACE 5

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