



MEMBERSHIP APPLICATION FORM 2009 / 10

Please return completed form to **PO Box 193 Surrey Hills VIC 3127** T: 03 9895 4463 F: 03 9898 0249 E: oa@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	MOAA
Given Name				Surname			
Maiden Name				DOB	/	/	
Home Address							
Suburb				Postcode			Country
Home Phone	(0)				Work Phone	(0)	
Mobile				Email*			

* Please note that the OAA 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 or New Zealand.

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](#) section of the Association website www.orthoptics.org.au

Federal Fee

- | | | | |
|--------------------------|--------|-----------|-----------|
| <input type="checkbox"/> | Gold | Ordinary | \$ 361.00 |
| <input type="checkbox"/> | Gold | Part-Time | \$ 216.00 |
| <input type="checkbox"/> | Gold | Associate | \$ 144.00 |
| <input type="checkbox"/> | Silver | Ordinary | \$ 415.00 |
| <input type="checkbox"/> | Silver | Part-Time | \$ 249.00 |
| <input type="checkbox"/> | Silver | Associate | \$ 166.00 |
| <input type="checkbox"/> | Bronze | Ordinary | \$ 469.00 |
| <input type="checkbox"/> | Bronze | Part-Time | \$ 281.00 |
| <input type="checkbox"/> | Bronze | Associate | \$ 187.00 |

NSW or VIC Branch Fees

(incl. Federal and State Fees)

- | | | | |
|--------------------------|--------|-----------|-----------|
| <input type="checkbox"/> | Gold | Ordinary | \$ 443.00 |
| <input type="checkbox"/> | Gold | Part-Time | \$ 298.00 |
| <input type="checkbox"/> | Gold | Associate | \$ 226.00 |
| <input type="checkbox"/> | Silver | Ordinary | \$ 497.00 |
| <input type="checkbox"/> | Silver | Part-Time | \$ 331.00 |
| <input type="checkbox"/> | Silver | Associate | \$ 248.00 |
| <input type="checkbox"/> | Bronze | Ordinary | \$ 551.00 |
| <input type="checkbox"/> | Bronze | Part-Time | \$ 363.00 |
| <input type="checkbox"/> | Bronze | Associate | \$ 269.00 |

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

Orthoptic Association of Australia Inc

PO Box 193 Surrey Hills, VIC, 3127

Direct transfer

Directly to our bank account:

Orthoptic Association of Australia Inc

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 OAA 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 OAA 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	