



MEMBERSHIP APPLICATION FORM

Please read and fill out each section carefully and include a copy of your CV with your application.

PART 1 - CONTACT DETAILS

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------|-----------|--------------------|--|
| Preferred Title: | | Given Names: | |
| Middle Name: | | Surname: | |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | | Mobile: | |
| Date of Birth: | | ** Personal Email: | |
| ** Alternate Email: | | | |
| <i>** Note: Please indicate your preferred email to receive ANZHNCs newsletter, correspondence and membership renewal information</i> | | | |
| Home address: | | | |
| State: | Postcode: | Country: | |
| Home Phone: | | Home Fax: | |
| Principal Place of Practice: | | | |
| State: | Postcode: | Country: | |
| Practice Phone: | | Practice Fax: | |
| Preferred Mailing and Billing Address: <input type="checkbox"/> Home <input type="checkbox"/> Work | | | |

PART 2 - EMPLOYMENT TYPE / STATUS

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Qualifications: | | |
| Specialty(s): Tick selection | | |
| <input type="checkbox"/> Allied Health (Dietetics / Speech Pathology / Physiotherapy / Occupational Therapy) <input type="checkbox"/> Anatomical Pathology <input type="checkbox"/> Dental (General Dentist / Special Needs/Special Care Dentistry / Oral Medicine / Oral Pathology / Other Specialist Dentist) | <input type="checkbox"/> Laboratory Research <input type="checkbox"/> Nursing <input type="checkbox"/> Oncology (Medical Oncology / Radiation Oncology) <input type="checkbox"/> Palliative Care <input type="checkbox"/> Radiology | <input type="checkbox"/> Surgery (ENT/ORL / Plastic and Reconstructive Surgery / Oral and Maxillofacial Surgery / General Surgery) <input type="checkbox"/> Anaplastology <input type="checkbox"/> Prosthodontist |
| State your Sub-Specialty(s): Tick selection | | |
| <input type="checkbox"/> Allied Health – Dietetics <input type="checkbox"/> Allied Health - Speech Pathology <input type="checkbox"/> Allied Health – Physiotherapy <input type="checkbox"/> Allied Health - Occupational Therapy <input type="checkbox"/> Anatomical Pathology <input type="checkbox"/> Oncology - Medical Oncology <input type="checkbox"/> Oncology - Radiation Oncology <input type="checkbox"/> Surgery - ENT / ORL Surgery | <input type="checkbox"/> Surgery - Plastic and Reconstructive Surgery (PRS) <input type="checkbox"/> Surgery - Oral and Maxillofacial Surgery (OMFS) <input type="checkbox"/> Surgery - General Surgery <input type="checkbox"/> Dental - General Dentist <input type="checkbox"/> Dental - Special Needs / Special Care Dentistry | <input type="checkbox"/> Dental - Oral Medicine <input type="checkbox"/> Dental - Oral Pathology <input type="checkbox"/> Dental - Dental Oncology <input type="checkbox"/> Dental - Other Specialist Dentist <input type="checkbox"/> Radiology |
| State your Sub-Specialty(s) - others: | | |
| Fields of Practice: | | |

Special Interest: _____

Which MDT are you a member of: _____

How did you hear about the Society: _____

Please include my contact details and employment type/status in the online Member's Directory: Yes No

PART 3 - NOMINATION FORM

Australian and New Zealand Head & Neck Cancer Society Limited
 (incorporated under the Associations Incorporation Act 1984)

I, _____
 (Full name of applicant)

of _____
 (address)

_____ (occupation)

Hereby apply to become an ORDINARY MEMBER of the Australian and New Zealand Head & Neck Cancer Society Limited

In the event of my admission as a member, I agree to be bound by the rules of the Society for the time being in force.
 To view a copy of the Society's Constitution please refer to website: <http://www.anzhncs.org>

Signature of applicant: _____ Date: _____

PART 4- MEMBERSHIP SUBSCRIPTION DETAILS

One off Joining Fees:

| Membership Category | Australian Application (INC GST) | New Zealand Application (Ex GST) |
|---------------------|----------------------------------|----------------------------------|
| Ordinary Member | \$50.00 AUD | \$40.00 AUD |

Annual Membership Subscriptions: (Please note: We accept payment in Australian Dollars only)

| Membership Category | Australian Application (INC GST) | New Zealand Application (Ex GST) |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------------------------|
| <p>Ordinary Member: Any person who is a registered medical or dental practitioner with a recognized specialist qualification in surgery, medicine or other medical disciplines eg. radiation oncology, pathology, radiology or neurosurgery, and/or a Fellowship in one of the Australasian Colleges, with particular interest in head and neck oncology; or has a tertiary qualification at doctoral level in a related discipline and is working actively in the field of head and neck oncology.</p> | <p>AUD \$220 incl. GST TOTAL: AUD \$220</p> | <p>AUD \$203 (No GST applic. for NZ members)</p> |

PART 5- PAYMENT DETAILS (payment is accepted by cheque, credit card or direct deposit to ANZHNCs bank account)

Membership Category (please tick)

Ordinary Membership

| | |
|----------------------|----|
| One Off Joining Fee: | \$ |
| Subscription Amount: | \$ |
| Total Amount: | \$ |

METHODS OF PAYMENT

(Please select one type of payment from below and please note 1.5% surcharge for Visa/Mastercard. New Zealand applicants may attract additional foreign transaction fees.)

PART 5A - PAYMENT BY CREDIT CARD

| | | | |
|--------------|-------------------------------|-------------------------------------|--------------------------------------|
| Type: | <input type="checkbox"/> Visa | <input type="checkbox"/> Mastercard | <input type="checkbox"/> Diners Club |
| Card Number: | | | |
| Expiry Date | CVV No: | Total Amount: | |

I authorize and request ANZHNCs to debit the above nominated credit card upon receipt of this authorization, in the event my application for membership is not approved, ANZHNCs will return any subscription amount paid. Note: There is a surcharge of 1.5% for Visa/Mastercard and 3.5% for AMEX

Card Holder's name:

Signature:

PART 5B - PAYMENT DIRECT DEBIT

You can pay via direct deposit into ANZHNCs bank account:

Bank: National Australia Bank
Account Name: Australian and New Zealand Head & Neck Cancer Society
BSB: 082-387 **Account No:** 45 726 7047
Your Ref: Surname

Date of Deposit:

Amount Deposited:

PART 5C - PAYMENT VIA CHEQUE OR MONEY ORDER:

I have enclosed a cheque / money order payable to Australian and New Zealand Head and Neck Cancer Society

PART 6 - PRIVACY POLICY

ANZHNCs values your privacy. For full privacy disclosure statement please refer to website: <http://www.anzhncs.org>

SUBMISSION CHECKLIST

Please make sure you have included the below before submission:

- Copy of Curriculum Vitae
- Payment details provided

PART 7 - WHAT HAPPENS NEXT

Upon receipt of your application, your payment will be processed. Payment of the subscription amount is accepted subject to approval of your application for membership by the Membership Subcommittee. If your membership application is approved, it will be formally ratified by the Executive at the next Executive Meeting and a welcome letter and receipt will be sent to you. As a member you will have access to all information emails sent to Members, access to our quarterly newsletter, and to the member login area of our website. Any application not approved will be notified by email and any subscription paid will be refunded to you.

PART 8 - APPLICATION SUBMISSION PROCESS

Please note: Due to our approval process, you will need to print out the Nomination Form section of this application form and have a Proposer and Secunder sign (both to be Ordinary members of ANZHNCs) and email this document, together with a copy of your current Curriculum Vitae to info@anzhncs.org or mail to: **ANZHNCs Secretariat, PO Box 576, Crows Nest 1585**