South Australian Indian Medical Association

Membership form
July 2016- June 2017

MEMBERSHIP CATEGORY **(please circle)**	**MEDICAL (Doctor / Dentist)**	**NURSING**	**ALLIED HEALTH**	**STUDENT Flin / Adel**
MEMBERSHIP FEE **(please circle)**	1 year $100 10 years $500	1 year $50 10 years $250	1 year $50 10 years $250	$0 grad year...........

Is your membership New or Renewal (please circle)

NAME: ……

AHPRA Registration Number………………………………………………………………………………

Discipline (GP / Specialist / Intern / RMO etc)…………………………………………………..

WORK NAME & ADDRESS: ………………………………………………………………………………..

………

HOME ADDRESS: ……………………………………………………………………………………………..

………

EMAIL CONTACT: ……………………………………………………………………………………………

PH: ………………………………… MOBILE: ………………………………………………………………..

Mode of Payment (please circle):

1. **Issue a cheque** in name of SAIMA and post to address below
2. **Electronic fund transfer** to BSB 105-139; Account number 36432740.
   Send remittance advice to tracey@amasa.org.au

3. Call Tracey on 08 8361 0105 to make payment over the phone by credit card.

In all cases provide form:

Email: tracey@amasa.org.au
Fax: 08 8267 5349
Post to: Tracey DiBartolo, AMA(SA), *PO Box 134, North Adelaide, SA 5006*
Enquiries: 08 8361 0105

OFFICE USE ONLY	MEMBERSHIP APPROVED	MEMBERSHIP FEE PAID

SAIMA Membership / Event Fee: Payments by Credit Card

Full Name: ____

Email: ____

Contact Phone: ________________________________ W ☐ H ☐

Mobile Phone: _________________________________

Credit Card Details

Card Type: Amex ☐ Visa ☐ MasterCard ☐ Diners ☐

Card Number: ____

Expiry Date: ____________________ Amount: ______________________

Cardholder's Name: ____

Cardholder's Signature: ____

Date: ________________________________

Amount Received	EVENT FEE & DATE	MEMBERSHIP FEE