Please indicate which Special Interest Group(s) you wish to join:

- [ ] Acute Pain
- [ ] Airway Management
- [ ] Anaesthesia and Critical Care in Unusual Transport Environments
- [ ] Leadership and Management
- [ ] Cardiac Thoracic Vascular and Perfusion
- [ ] Communications in Anaesthesia
- [ ] Day Care Anaesthesia
- [ ] Diving and Hyperbaric Medicine
- [ ] History of Anaesthesia
- [ ] Medical Education
- [ ] Neuroanaesthesia
- [ ] Obstetric Anaesthesia
- [ ] Perioperative Medicine
- [ ] Regional Anaesthesia
- [ ] Rural
- [ ] Trauma
- [ ] Welfare of Anaesthetists

MEMBERSHIP TYPE

Membership is of two types; please indicate the type applied for:

- [ ] MEMBER: (Fellows of ANZCA, or Ordinary Members of the ASA or NZSA)
  
  Please indicate your affiliation/s:
  - [ ] Fellow of ANZCA
  - [ ] Ordinary Member of ASA
  - [ ] Ordinary Member of NZSA

  Please note: As Special Interest Groups (SIGs) are managed by ACECC (a tripartite of ANZCA, ASA and the NZSA), as a SIG member you may receive information from all three organisations.

- [ ] ASSOCIATE MEMBER:

  People with special interests, who are not eligible to be full members. These may include Associate Members of the ASA or NZSA; registered Trainees of ANZCA allied health professionals or members of other related professional organisations.

  Associate Members require nomination by two full members of the SIG and approval by majority at a meeting of the Executive Committee of the SIG. Please ensure the following section is completed.

  NOMINATION

  We wish to nominate…………………………………………… to Associate Membership of the ……………………………………………………………...Special Interest Group.

  ____________________________________________________________  ____________________________________________________________
  Signature                                                         Print Name (Full member of SIG)

  ____________________________________________________________  ____________________________________________________________
  Signature                                                         Print Name (Full member of SIG)

Please complete section overleaf
DETAILS OF APPLICANT

Surname: __________________________ Title: ______________________

Other Names: ______________________ Date of Birth: ____/____/____

Gender: __________________________

Hospital: ______________________________________________________

Preferred Mailing Address
Please indicate if this is: Home □ Work □

________________________________________________________

City: __________________________ State: ______ Postcode: ______

Country: ______________________ Email: ______________________

H Phone: (____)_______________ H Fax: (____)_______________

W Phone: (____)_______________ W Fax: (____)_______________

Mobile: ______________________

Basic Degree: ______________________ Year: _____________________

University: __________________________________________________

Specialist Qualification: ______________________ Year: _____________________

Signed: .................................................................

Date: ........../........./.........

Email or mail to:

ANZCA

Email: events@anzca.edu.au
Australian and New Zealand College of Anaesthetists,
630 St Kilda Road, Melbourne VIC 3004, Australia.
Tel: +61 3 9510 6299 Fax: +61 3 9510 6786

Or

ASA

Maxine Wade
Email: mwa@asa.org.au
Australian Society of Anaesthetists,
PO Box 6278, North Sydney, NSW 2059 Australia.
Tel: +61 2 8556 9726 Fax: +61 2 8556 9750

Office use
Approved by SIG Executive on ____/____/____

Received: ______________________