

Non-Fellow Application Form



PERSONAL DETAILS

Family Name: _____ First Name: _____
 Middle Name: _____ Preferred Name: _____
 Gender: **M** **F** Date of Birth: __ / __ / ____ Country of Birth: _____

CONTACT DETAILS

Please tick preferred

Home Address: _____
 Suburb/City _____ State: _____
 Postcode: _____ Country: _____

Work Address: _____
 Suburb/City _____ State: _____
 Postcode: _____ Country: _____

PHONE

Please tick preferred

Home: _____ Mobile: _____
 Work: _____ Fax: _____

EMAIL

Please tick preferred

Personal: _____
 Work: _____

QUALIFYING MEDICAL DEGREE

Including Specialist qualification Details

Please attach copies of relevant documents

Title of Qualification	University/College	Graduation Year	Area of Study

PARTICIPATION TYPE

Please indicate if you would prefer to participate via the online portfolio or on a hardcopy portfolio

Online

Offline

MEDICAL REGISTRATION

Please provide a copy of your medical registration in Australia and/or New Zealand

Registration Number: _____

Registration Number: _____

DECLARATION OF APPLICANT

I certify that I am currently registered as a medical practitioner with my national medical board/council. I am willing to provide evidence of compliance with the Continuing Professional Development if requested by the Australian and New Zealand College of Anaesthetists.*

Signature: _____

Date: _____

*New Zealand applicants should read and consent to the Conditions of Application below

New Zealand Privacy Act 1993:

1. I acknowledge that:
 - a. The personal information concerning me provided to the Australian and New Zealand College of Anaesthetists (the "College") contained in this application or otherwise obtained or provided to the College in the course of the Continuing Professional Development Program ("CPD Program") is provided and may be held, used and disclosed by the College for the processing my application for participation in the CPD Program, administering, maintaining or notifying my application in or otherwise for the purposes of the CPD Program and communication with me for any purpose.
 - b. The personal information provided in this proposal is collected and will be held by the College address is 630 St Kilda Road, Melbourne, Victoria, 3004, Australia.
 - c. If I fail to provide any information requested in this application the College may be unable to process or accept this application and/or permit my participation in the CPD Program.
 - d. I have the right under the Privacy Act 1993 to obtain access to and correction of any personal information held by the College for the purpose of my participation in the CPD Program concerning me.
2. I authorise the College to obtain at any time from any person or entity (including but not limited to those persons nominated in this application), any information the College may require to:
 - a. Process and/or accept this application.
 - b. To verify and confirm any information or details may provide to the College in the course of the CPD program
 - c. To service and maintain my participation in the CPD Program and to enable the College to properly perform all its functions and powers in respect of participation in the CPD Program.

I authorise any such person to release to the College any personal information that person holds concerning me.

Providing information to the MCNZ:

I give permission for the College to verify my successful participation in the ANZCA Continuing Professional Development Program to the Medical Council of New Zealand upon request.

Signature: _____

Date: _____

