

ANZCA/ASA/NZSA

**SPECIAL INTEREST GROUP
MEMBERSHIP APPLICATION FORM**

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

- | | |
|---|--|
| <input type="checkbox"/> Acute Pain | <input type="checkbox"/> Medical Education |
| <input type="checkbox"/> Anaesthetists in Management | <input type="checkbox"/> Neuroanaesthesia |
| <input type="checkbox"/> Cardiothoracic, Vascular and Perfusion | <input type="checkbox"/> Obstetric Anaesthesia |
| <input type="checkbox"/> Critical Care in Unusual Environments | <input type="checkbox"/> Regional Anaesthesia |
| <input type="checkbox"/> Day Care Anaesthesia | <input type="checkbox"/> Rural |
| <input type="checkbox"/> Diving and Hyperbaric Medicine | <input type="checkbox"/> Simulator and Skills Training |
| <input type="checkbox"/> History of Anaesthesia and Resuscitation | <input type="checkbox"/> 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

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. (An annual membership fee may be applicable.)

NOMINATION

We wish to nominate..... to Associate Membership of theSpecial 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:** ____/____/____

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: _____

I wish my name and mailing address to be included in the Combined Mailing List for educational information from ANZCA, ASA and NZSA.

Signed:

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

Mail to (including fee if applicable):

Ms Kate Briggs
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 Email: kbriggs@anzca.edu.au

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

Fee Applicable: \$ _____ Received: _____