AADA Registration Form

Please tick one: ☐ **Existing member (Fill in part A of form and sign below)**

Or

☐ **New member (Fill in part A and B and sign below)**

PART A

Name:

AADA Membership ID:

Work Address:

Postal Address:

Contact Telephone Number:

Email Address:

PART B

Medical Qualifications:

Type of Medical Practice:

Special Medical Interests:

Name of Existing AADA Member Nominating you as a Member:

Signature: ______________________ **Date:** ________________

PAYMENT DETAILS ($150): *(Payment is accepted by **direct debit ONLY!**)*

EFT* (*The Commonwealth Bank of Australia - CBA*):

Account name: **AADA Subscriptions**
BSB: **06 4178**
Account number: **1055 8384**

** When using **direct debit, existing members** please quote your **AADA membership ID** and **name**; for **new members** (or updating contact details)**,** please post a copy of your **EFT payment receipt** along with your **membership registration form** to Dr. Rose NIU. A membership ID will be assigned to a new member once the payment is processed. (Postal Address: Dr. Rose NIU Q Skin Clinic, Lutwyche City Shopping Centre, Shop 46, 543 Lutwyche Road, Lutwyche, QLD 4030)*

Please note that the membership year is from **1 July 2017 to 30 June 2018***. Regardless of when a member joins during this period, the full membership fee will apply.*