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:

Work Address :

Postal Address :

Work 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:**

Please return form and payment of $80 (cheque addressed to "AADA Inc.") to:
Dr Michael Marfan
PO Box 8062, Sunnybank Q4109

Please note that the membership year is from 1 July to 30 June. Regardless of when a member joins during this period, the full membership fee will apply. Please note also that you must be a member of AADA for at least 6 months before attending an AADA conference.