



KURING-GAI DISTRICT
MEDICAL ASSOCIATION

KURING-GAI DISTRICT MEDICAL ASSOCIATION INC.
PO Box 284, EASTWOOD, NSW, 2122
TELEPHONE : (02) 9872 6981; FAX (02) 9872 6061; *kdma@netspace.com.au*
ABN 455 152 840 65

**TAX INVOICE UPON PAYMENT
MEMBERSHIP APPLICATION**

Please Print clearly:

SURNAME: _____ **FIRST NAME:** _____ **TITLE:** _____

SURGERY: _____

_____ **POST CODE:** _____

PHONE: (W) _____ **(H)** _____ **FAX:** _____ **MOBILE:** _____

HOME: _____

_____ **POST CODE:** _____

E-MAIL ADDRESS: _____

MAIL TO: HOME []... or ...WORK []; **SPOUSE'S NAME:** _____

MAJOR SPECIALTY: _____ **SECONDARY SPECIALTY:** _____

GP? YES [] NO [] - IF YES, STATE ANY SPECIFIC MEDICAL INTEREST PRACTISED: _____

MEMBER OF AMA? YES [] NO []

SCALE OF FEES FOR 2005

(NB: Half of annual fee only is payable if joining after 1st July.)

MEMBER TYPE & 2003 FEE	FEES	10% GST	TOTAL DUE	PLEASE TICK YOUR MEMBERSHIP CATEGORY
Full-Time	\$130.00	+ \$13.00	\$143.00	
Part-Time**(see below)	\$97.50	+ \$9.75	\$107.25	
Country/Student	\$25.00	+ \$2.50	\$27.50	

Please return this duly completed application form, together with cheque made payable to KDMA, to:
The Hon. Treasurer, KDMA, PO Box 284, EASTWOOD, NSW, 2122

Please tick appropriate Membership request:

- I hereby apply for **Full Time Membership/*Associate Membership** of the Kuring-gai District Medical Association and agree to abide by its Rules and Regulations.
- I hereby apply for ****Part-Time Membership/Associate Membership** of the Kuring-gai District Medical Association and agree to abide by its Rules and Regulations. I declare that my gross income from all medically related pursuits is \$40,000 or less, per annum.
- I hereby apply for **Country/Student Membership** of the Kuring-gai District Medical Association and agree to abide by its Rules and Regulations.

Signed: _____

Date: ____/____/____

(NB: *Associate Membership is open to non-Members of AMA)