

UPDATE YOUR MEMBERSHIP DETAILS



Please use this form to notify changes either to your contact details or employment arrangements.

Date changes apply: / / .

TITLE: Dr <input type="checkbox"/> Prof <input type="checkbox"/> A/Prof <input type="checkbox"/> Mr <input type="checkbox"/>		GENDER: Male <input type="checkbox"/> Female <input type="checkbox"/>	
PLEASE PRINT CLEARLY			
SURNAME:		GIVEN NAMES:	
HOME/POSTAL ADDRESS:			
			P/CODE:
CONTACT NO:		HOME:	
WORK:		MOBILE:	
FAX:		EMAIL:	
AMA MEMBER: (please circle) YES / NO			
I AM EMPLOYED AS: (please circle)		MY HOURS ARE: (please circle)	
INTERN		FULL- TIME	
MP2 (RMO 2nd yr)		PART-TIME (10ths) 1 2 3 4 5 6 7 8 9	
AMC TRAINEE			
MEDICAL PRACTITIONER (3-8)		VMS SESSIONS 1 2 3 4 5	
SENIOR REGISTRAR			
CONSULTANT		CASUAL	
SNR MED PRACTITIONER/MED OFFICER		EMPLOYER:	
VISITING MEDICAL SPECIALIST		WORKPLACE (Health Unit)	
CLINICAL ACADEMIC			
RESEARCH			
		DEPARTMENT:	
I AM EMPLOYED: (please circle)		SPECIALTY/IES:	
PRIVATE PRACTICE YES / NO		ACCREDITED TRAINING PROGRAMME: Yes / No Which one?	
OTHER NON-GOVERNMENT YES / NO			

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