



# Membership Application Form 2009

## Membership type (please select):

Primary Membership:  (are you a GP?) Yes  No   
 Registrar Membership:   
 Associate Membership:  (not all sections will need to be completed)

## Personal details - Please complete the following form to ensure we have your correct information.

Title: \_\_\_\_\_ First name: \_\_\_\_\_ Surname: \_\_\_\_\_

Male/Female (please circle)

## Contact Information:

Practice: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Please tick if you would like to receive the OGPN weekly update via email

Other Practice Name(s): \_\_\_\_\_  
 \_\_\_\_\_

Postal address: (if different to address listed above)

\_\_\_\_\_  
 \_\_\_\_\_

Please tick if this is a home address (OGPN does not release home address details)

## For General Practitioner to complete:

★QA & CPD Number: \_\_\_\_\_ \*Provider Number: \_\_\_\_\_ \*HIC Prescriber Number: \_\_\_\_\_

★ This information may be used when you participate in educational activities  
 \* This information is collected to ensure any activities undertaken for the Quality Prescribing Initiative Practice Incentive Program can be credited to your practice.

ABN:  GP registered for GST **OR**  Use my Practice ABN

Please tick if you are an International Medical Graduate (IMG)

## Release of Information:

At times the Osborne GP Network is approached by health organisations and prospective patients to provide details of general practitioners and health providers working within our area. The Network will provide your information (information that is normally found in the yellow pages – eg: Dr name, Practice name, address, telephone and fax) to the following groups if you tick the box(es) below to indicate you allow the Network to release it. Every attempt is made to ensure your privacy. Please note OGPN does **not** provide your details to pharmaceutical companies.

I authorise release of the above information to ALL of the areas listed below

**OR** I authorise the above information to be released to: (specify which you authorise by ticking the appropriate box)

- \*\* Other GPs and Practices (eg, for referral purposes)
- State Health Services (incl. Hospitals and other government health services)
- Other Health Care Providers (incl. Private Hospitals and Specialists)
- Allied Health Professionals
- \*\* Individual members of the community (eg, if trying to locate a GP speaking Italian)
- Universities / Research Institutions

\*\* Languages able to consult in: \_\_\_\_\_

\*\* Special clinical interests: \_\_\_\_\_

\*\* This information is released only to those areas asterisked above, with your authorisation. Example: A GP contacts OGPN to locate a fellow GP who will perform a Vasectomy or a member contacts OGPN to locate a GP who speaks Italian etc.

**Mail Outs:** The Network will, from time to time, facilitate the dissemination of information to you from external organisations, by way of a mail out. Please note your address details are not supplied to the organisation, and any material to be sent is authorised for distribution by our CEO. Please also refer to the OGPN Privacy Policy.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please turn over to authorise/confirm your payment method.

## **Membership Application**

*(please note that membership is free for GP registrars)*

I wish to apply for membership of Osborne GP Network Ltd. I have read the privacy statement attached in regards to personal information and agree to the terms. My cheque (made payable to Osborne GP Network Ltd) for the Primary Member annual subscription of \$66 (incl. GST) for Primary Membership or \$33 (incl. GST) for Associate Membership is attached. Alternatively a direct bank deposit can be made into the following account:

ANZ  
BSB 016 334 Account Number 2597-57256 (please quote the invoice number or GP name if a direct bank deposit is made)

My cheque is enclosed

I have made a direct bank payment

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_