



## APPLICATION FOR MEMBERSHIP

Office Use Only

ADAVB Member No.  ADAVB Classification  Guild Category

### Section 1 -Declaration by Applicant

Have you currently or in the past had a statutory complaint upheld against you or have you had membership of this organisation, or similar organisation, refused or terminated?  Yes  No

I, ..... hereby apply to become a member of the Australian Dental Association Victorian Branch Inc. (ADAVB). If elected to be a member of the Association, I agree to be bound by the Rules and By-Laws\* made by the Association or the Council. I undertake at all times to uphold the professional and ethical obligations of membership. I also understand that election to membership also includes mandatory membership to the Australian Dental Association Inc. (Federal), by virtue of requirements under the Constitution, Rules and By-Laws\* of the ADAVB. I certify that I am currently registered with the Dental Board as a dentist in Victoria. I hereby state that all information supplied is true and correct. I am aware that any omission or false declaration in this application may lead to Council declaring my membership denied or annulled.

I understand that in considering my application, the ADAVB may need to review my personal information relating to my current and previous dental registration, dental association membership and professional indemnity insurance/claims history. I consent to the ADAVB seeking access to such information and using that information for the purposes of considering my application and to the relevant organisation disclosing such information.

Signature

Date

\* A copy of the Rules and By-Laws of the ADAVB can be viewed at [adavb.net](http://adavb.net). Click on Resources>Documents.

### Section 2 -Personal Details (please provide your legal name as per your AHPRA registration)

Title	<input type="text"/>	Preferred mailing address	<input type="text"/>
First Name	<input type="text"/>		<input type="text"/>
Surname	<input type="text"/>		<input type="text"/>
Phone (home)	<input type="text"/>	Town/Suburb	<input type="text"/> Postcode <input type="text"/>
Phone (mobile)	<input type="text"/>		
Email	<input type="text"/>	Home address	<input type="text"/> Same as mailing
Date of birth	<input type="text"/>		<input type="text"/>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="text"/>
AHPRA Reg. Number	<input type="text"/>	Town/Suburb	<input type="text"/> Postcode <input type="text"/>
AHPRA Reg. Date	<input type="text"/>		
Do you have any conditions/undertakings on your registration	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If 'Yes' please describe	<input type="text"/>		

### Section 3 -Qualifications

Year graduated	<input type="text"/>	Qualification	<input type="text"/>
University attended	<input type="text"/>	Country of graduation	<input type="text"/>
Speciality	<input type="text"/>	University attended	<input type="text"/> Year graduated <input type="text"/>
Were you required to complete an ADC exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If 'Yes' What is the date on your ADC Certificate?	<input type="text"/>	In which State did you sit your exam?	<input type="text"/>

Please attach a copy of your ADC Certificate to this application.

PLEASE CONTINUE OVERLEAF

## Section 4 – Insurance Details

Do you currently have a policy with Guild Insurance?  Yes  No

If "Yes"

Client Number

Do you pay by the month?  Yes  No

If "No"

Name of Insurer

Client number

## Section 5 – Employment Details

Are you the practice owner?  Yes  No

Are you an employee?  Yes  No

Are you doing post graduate studies in dentistry?  Yes  No

Are you retired from dentistry?  Yes  No

## Section 6a - 1<sup>st</sup> Practice

Total hours worked per week in this practice

Hours p/w

Type of practice

Private sector

Public sector

University

Armed services

Practice structure

Sole practitioner

Service company

Company

Associate practice

Trust

Partnership practice

Registered specialties

Practice address

Town/Suburb  Postcode

Phone

Fax

Email

Website

Facilities (e.g. Wheel chair access, Multi-lingual, Intravenous)

## Section 6b – 2<sup>nd</sup> Practice

Total hours worked per week in this practice

Hours p/w

Type of practice

Private sector

Public sector

University

Armed services

Practice structure

Sole practitioner

Service company

Company

Associate practice

Trust

Partnership practice

Registered specialties

Practice address

Town/Suburb  Postcode

Phone

Fax

Email

Website

Facilities (e.g. Wheel chair access, Multi-lingual, Intravenous)

## Section 7 – Payment

Following approval of your Application for Membership by our Executive Committee and/or Branch Council, you will be sent a Membership Tax Invoice. This payment will be calculated pro-rata from commencement of membership to 30 June. Payments can be made in a one-off payment or by monthly instalments, upon completion of a direct debit request form.

Membership rates are determined by your membership classification. To obtain a quote please contact the Membership Officer on 8825 4600 or ask@adavb.org.

**Please return to: ADAVB, PO Box 9015, South Yarra Vic 3141  
Level 3, 10 Yarra Street, South Yarra Vic 3141  
Phone: 03 8825 4600 Fax: 03 8825 4644  
ask@adavb.org www.adavb.net**