AUSTRALIAN DENTAL ASSOCIATION
VICTORIAN BRANCH INC.
ABN 80 263 088 594 ARBN 152 948 680 Reg'd Assoc No. A0022649E

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.org / resources / documents.

Section 2 -Nomination of Applicant**

**Both Proposer and Seconder MUST be financial members of the Australian Dental Association Victorian Branch Inc. And either one must have personal knowledge of the Candidate.

We, the undersigned, hereby certify that the above-named applicant is a fit and proper person to be elected as a member of the ADAVB and the ADA Inc. And support this application.

Proposer

Name

ADAVB Member No

Signature
Date

Seconder

Name

ADAVB Member No.

Signature
Date

Section 3 -Personal Details *(please provide your legal name as per your AHPRA Registration)*

Title

First Name

Surname

Phone (home)

Phone (mobile)

Email

Date of birth

Gender Male Female

AHPRA Reg. Number

AHPRA Reg. Date

Preferred mailing address

Town/Suburb Postcode

Home address *Same as mailing*

Town/Suburb Postcode

Do you have any conditions/undertakings on your registration Yes No
If 'Yes" please describe

Section 4 –Qualifications

Year graduated

University attended

Speciality

Qualification

Country of graduation

University attended Year graduated

Were you required to complete an ADC exam? Yes No

If 'Yes" What is the date on your ADC Certificate

In which State did you sit your exam?

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

PLEASE CONTINUE OVERLEAF

Section 5 – 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 6 – 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 7a - 1st 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 7b – 2nd 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 8 – Payment

Following approval of your Application for Membership by our Executive Committee and/or Branch Council, you will be sent a Subscription 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 subscription rates are determined by your membership classification. To obtain a quote please contact the Membership Officer at the Branch Office.

Please Return to: ADAVB, PO Box 9015, South Yarra Vic 3141
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