


Application form – Membership



Overseas registered medical practitioners (new or rejoining members)
1 July 2019 to 30 June 2020

ACN 000 223 807 ABN 34 000 223 807

Please print letters. Use black or blue pen
and place in all applicable boxes.

Please return form to:

 The Royal Australian College
of General Practitioners Ltd
Reply Paid 88254
East Melbourne Victoria 8002

 03 8699 0489
 membership@racgp.org.au

RACGP number
(office use only)

Membership category

Did you know you can become an RACGP member online? Visit racgp.org.au/membership/join

☐ RACGP Fellow ☐ Member ☐ Associate

Requires five years specialist registration with AHPRA, five years consecutive participation in the RACGP QI&CPD Program and two referees.
Existing QI&CPD participants can become a 'Member' upon meeting the above eligibility criteria and completing the 'QI&CPD participants seeking Member status' section on page 2 of this form.

Personal details

Prefix <input type="text"/>	First name <input type="text"/>	Last name <input type="text"/>	Preferred name <input type="text"/>
Home address <input type="text"/>		Suburb <input type="text"/>	State <input type="text"/>
Telephone <input type="text"/>		Fax <input type="text"/>	Email <input type="text"/>
Mobile <input type="text"/>		Date of birth <input type="text"/>	Gender (tick one) Male <input type="checkbox"/> Female <input type="checkbox"/>

Practice details

Practice name <input type="text"/>		Practice address <input type="text"/>	
Suburb <input type="text"/>	State <input type="text"/>	Postcode <input type="text"/>	Telephone <input type="text"/>
Work email address <input type="text"/>		Preferred email address Practice <input type="checkbox"/> Home <input type="checkbox"/>	
		Preferred postal address Practice <input type="checkbox"/> Home <input type="checkbox"/>	

I am of Australian Aboriginal or Torres Strait Islander origin

No ☐ Yes, Australian Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both ☐ Prefer not to say ☐

Additional options

I would like to receive RACGP news bulletins, major health information, RACGP notices including event/workshop notices and updates from the RACGP, via email or via emailed links to the RACGP website

Yes ☐ No ☐

I would like to join RACGP Specific Interests*

Yes ☐ No ☐

I would like to join RACGP Aboriginal and Torres Strait Islander Health*

Yes ☐ No ☐

I would like to join RACGP Rural*

Yes ☐ No ☐

**RACGP members receive complimentary membership to their state, and can choose to join RACGP Specific Interests, RACGP Aboriginal and Torres Strait Islander Health and RACGP Rural on a complimentary basis.*

Academic background

Primary qualification

Date	Qualification	University/College/Country
<input type="text"/>	<input type="text"/>	<input type="text"/>

Other medical qualifications

Date	Qualification	University/College/Country
<input type="text"/>	<input type="text"/>	<input type="text"/>

☐ I have attached a copy of my primary medical degree (transcribed in English)

Medical registration

Medical registration number

Full	Date <input type="text"/>	Registration body	<input type="text"/>
Provisional	Date <input type="text"/>	Registration body	<input type="text"/>

☐ I have attached a copy of my current overseas medical registration certificate/card (transcribed in English).

☐ I have supplied a current Letter of Good Standing from the registering body (officially transcribed in English). This is an essential requirement for overseas registration issued more than two years ago (it is not required for overseas medical registration issued less than two years ago).

Declaration

By signing and returning this membership application to the RACGP (or by paying the membership fee) I acknowledge I make the following declarations for the RACGP's benefit:

- (1) I will uphold and promote to the best of my ability the aims and objectives of the RACGP.
- (2) I will comply with the RACGP Constitution and such regulations as may, from time to time, be in force.
- (3) I will satisfy all appropriate Quality Improvement and Continuing Professional Development (QI&CPD) requirements of the RACGP.
- (4) My contact and all other details as advised are true and correct.
- (5) As required, I hold the appropriate AHPRA registration for my classification as a medical practitioner (or reside overseas and am registered under the local equivalent), and know no reason for why this would change.
- (6) I understand any breach of Declarations (1) to (5), or any failure to pay my membership fee, may result in my suspension or expulsion from Fellowship or membership, or may impact on my future membership opportunities.
- (7) I consent to the RACGP collecting, using and disclosing my personal information for the purposes of administering my membership, managing my registration and education (including liaising with AHPRA, Medicare and training organisations as necessary and its related bodies corporate such as RACGP Oxygen Pty Ltd).
- (8) I consent to the RACGP using or disclosing my personal information in limited subsets (such as my contact details) and to Member Benefit Partners for their use in providing me with materials about their goods or services.
- (9) I understand I may withdraw my consent to this disclosure by notifying the RACGP of my decision to opt-out from these.

Signature

Date

The RACGP Constitution can be viewed at racgp.org.au/constitution
The RACGP Privacy Statement can be viewed at racgp.org.au/usage/privacy

Membership payment

Once your application is processed, an invoice will be sent to you with your membership fee via your preferred contact method.