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.net. Click on Resources>Documents.

Section 2 -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 3 –Qualifications

Year graduated
University attended
Speciality
Were you required to complete an ADC exam?
If 'Yes" What is the date on your ADC Certificate?

Qualification
Country of graduation
University attended
Year graduated
Yes No
In which State did you sit your exam?

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 - 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 6b – 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 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.
Please indicate your preferred payment method:
A: Monthly or Annually B: Credit Card; Direct Debit or Cheque
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