



Riverland Division
of General Practice Inc.

RIVERLAND RURAL MEDICAL FAMILY NETWORK

Membership Registration Form

FOR PARTNERS AND FAMILIES OF RDGP MEDICAL MEMBERS

Name of RDGP Member

RMFN member registration details:

First Name

Date of Birth

Occupation

Languages spoken

Any special dietary or medical considerations

Employer

Children (dependant details)

Name

Date of Birth

Name

Date of Birth

Name

Date of Birth

Name

Date of Birth

Any special dietary or medical considerations

Languages spoken

Residential Address

Postcode

Postal Address

Postcode

Telephone

home

business

mobile

Email Address

Country of origin

Nationality

Religion

Social, sporting or other interests

Your Signature

I agree to the terms and conditions of this application.
Please type your name here when submitting electronically.

Date



Photographs

During events and activities organised by RDGP and Riverland RMFN we may take photographs of our members and/or their families.

Traditionally we have used some of these photographs for promotional purposes in our publications, newsletters and on our website.

RDGP requires your permission, in writing, to publicise photographs of members and their families. Please complete the consent section of this page and return it to RDGP.

I

give my permission for the Riverland Division of General Practice to take photographs of my family and I.

I understand that these photographs may be used in publications, newsletters or on the RDGP website.

This authorisation remains current until RDGP is notified in writing to the contrary.

Your Signature

I understand and agree to these terms and conditions related to RDGP's use of photographs. Please type your name here when submitting electronically.

Date / /