



Riverland Division of General Practice Inc.

RIVERLAND DIVISION OF GENERAL PRACTICE

# Practice Membership Form

### Personal Details:

Surname

First Name

Date of Birth

Residential Address

Postcode

Postal Address

Postcode

Telephone home

business

mobile

Email Address

Any special dietary or medical considerations

Social, sporting or other interests

### Professional Details:

Name of practice

Date commenced at practice

Position held within practice. Please tick.

Practice Manager

Practice Nurse

Clerical Staff

Allied Health

RNCA Number (for nurses)

Graduation details:

When

Where

Qualifications

Areas of professional interest

Procedural skills

Upskilling/CPD priorities

Non medical qualifications/training

Professional representation on other boards/committees  
(eg RWDA, FURCS, HACs)

Current social/community organisation membership  
(eg service or sporting clubs)

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  /  /