



ASSOCIATE MEMBERSHIP NOMINATION FORM

I, (full name, block letters)

wish to apply for membership of the Australian Dental Prosthetists Association Queensland and if accepted, do hereby agree to abide by its Rules of Incorporation and Code of Conduct. I have current registration with the Dental Technicians Registration Board.

Name <i>Please print</i>		Date of Birth
Business Name & Address		Ph Fax Mob
Private Address		Ph Fax Mob
Email		
Send correspondence via: Mail - Private <input type="checkbox"/> Business <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/>		
Qualification		Date of Qualification
Institute		
State, Country		
Qld Technician Registration Number		
Signature of Applicant		Date
Proposer: (print name)		Sign:
Seconder: (print name)		Sign:
Please Note: Proposer and Seconder must be financial Ordinary members of the ADPAQ		
An annual discounted fee for Associate Membership of \$77.00 must accompany this form. A tax invoice/receipt will be forwarded to you on receipt of this payment.		
Please forward this signed form & your cheque payment or credit card details to: The Australian Dental Prosthetists Assoc Qld Inc, Shop 9, 235 Zillmere Road, Zillmere 4034. For payment by direct deposit: Commonwealth Bank BSB No: 06 4134 A/c No: 10000682 Cheques payable to: Australian Dental Prosthetists Assoc Qld Inc. Payment by Credit Card please complete the below details:		
Name on Card _____		
Signature _____ Amount Paid _____ Date _____		
Credit Card No _____ Expiry __ / __ Visa/Mastercard		