

# AGPAL ACCREDITATION – General Practice Registration Form



Complete this form and mail to AGPAL, PO Box 2058, Milton BC QLD 4064.

## Accreditation contact details *(This is the person who will liaise with AGPAL throughout the accreditation process)*

Preferred accreditation contact	Name: _____ Position: _____
Other accreditation contact	Name: _____ Position: _____

## Practice details

Practice name	_____
Street address	_____ _____ Suburb: _____ State: _____ Postcode: _____
Postal address (if different from the street address)	_____ _____ Suburb: _____ State: _____ Postcode: _____
Telephone	_____
Facsimile	_____
Email	_____
Website	_____
Are you part of a corporate entity?	<input type="checkbox"/> Yes (please provide details) _____ <input type="checkbox"/> No

## Demographic details

Is your practice considered a/an:	<input type="checkbox"/> Aboriginal Medical Service <input type="checkbox"/> RACGP Teaching Practice <input type="checkbox"/> Royal Flying Doctor Service <input type="checkbox"/> Other (please specify below) _____
What is the <b>rurality</b> classification of your practice?	<input type="checkbox"/> Non-rural <input type="checkbox"/> Rural
What is the <b>RRMA</b> classification of your practice?	_____ (Go into <a href="http://www.healthworkforce.com.au/main_rrma.asp">http://www.healthworkforce.com.au/main_rrma.asp</a> to identify your RRMA)
What is the <b>Division</b> classification of your practice?	_____



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ONLY COMPLETE THE SECTION BELOW IF YOUR PRACTICE IS APPLYING FOR ACCREDITATION AS A **GENERAL PRACTICE AND AFTER HOURS SERVICE**.

**Practitioner(s):** *List all practitioners working at your practice during the after hours period at the date of registration.*

Name of practitioner	Total hours worked per week

## The next step

Please forward your registration fee of \$550 (including GST) to AGPAL. **Online payment is preferred.** Alternatively, please forward your cheque or money order to AGPAL, PO Box 2058, Milton BC QLD 4064.

<input type="checkbox"/> Credit card	<input type="checkbox"/> Visa	<input type="checkbox"/> Mastercard
Cardholder's name:		_____
Card number:		_____/_____/_____/_____
Expiry date:		____/____
Amount:		\$550.00
Signature:		_____

## Authorisation

I, \_\_\_\_\_, as the accreditation contact named in this registration form and authorised to act for and on behalf of the Practice, acknowledge that I have read and accept the Terms and Conditions contained in the Client Agreement available at [www.agpal.com.au](http://www.agpal.com.au).

Signature	
Print full name	
Date	

**Thank you for completing this registration form and we welcome you to AGPAL accreditation.**

## Office use only

Practice ID:		Processed date:	
Payment F/U:		Registration letter sent:	

Our Ref: F:\PRACTICES\2 - QUALITY IMPROVEMENT SERVICES\1 - Information Kit\2 - GP Registration Form 170309NP.doc