

Type of Membership:

- Full Membership
 Associate Membership
 Registrar Membership

Professional and Contact details	Please list any changes to your details below:
Title: Dr <input type="checkbox"/> Prof <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/>	
Surname:	
First Name:	
Category: General Practitioner <input type="checkbox"/> Medical Specialist <input type="checkbox"/> Allied Health <input type="checkbox"/> Nurse <input type="checkbox"/> Practice Staff <input type="checkbox"/> Other (please specify).....	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Age Range: Under 35yrs <input type="checkbox"/> 35-44yrs <input type="checkbox"/> 45-54yrs <input type="checkbox"/> 55-64yrs <input type="checkbox"/> 65yrs plus <input type="checkbox"/>	
QA&CPD No.	
Provider No.	
Registration No.	
Languages Spoken:	
Did you gain your medical qualifications in a country outside Australia (IMG)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are you Vocationally Registered (VR)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are you registered for ANSC? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Contact details (for all correspondence)	
Postal Address: (including Practice Name):	
Telephone:	
Fax:	
Mobile:	
Email:	
Preferred Correspondence Method: Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/>	
Principal Practice Address:	
Practice Name:	
Physical Address: (if same as above please write AS ABOVE)	
Telephone:	
Fax:	
Email:	
Hours you work at this practice per week:	
Practice Information:	
Type of Practice: Solo <input type="checkbox"/> 2-5 GP Practice <input type="checkbox"/> 6 or more GP Practice <input type="checkbox"/> Corporate <input type="checkbox"/>	
Is your Practice Accredited: Yes <input type="checkbox"/> No <input type="checkbox"/> AGPAL <input type="checkbox"/> GPA <input type="checkbox"/>	
Are you interested in becoming Accredited: Yes <input type="checkbox"/> No <input type="checkbox"/>	
PIP Registration: Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Cervical Screening <input type="checkbox"/> e-health <input type="checkbox"/> Indigenous Health <input type="checkbox"/>	
After Hours GP Service: Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, opening hours.....	
Home Visits: Yes <input type="checkbox"/> No <input type="checkbox"/>	
No. of GPs who do home visits.....	
Do you accept new patients to the Practice? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Practice Information (continued):**Do you have a:-**

Principal GP: (name)

Practice Manager: (name)

Practice Staff: (name)

Practice Nurse: (name).....

.....

Type: Registered Nurse Enrolled Nurse

No. of Nurses in your Practice

If you do not employ a nurse, please tick the reason why not?Lack of Space Not eligible for practice nurse PIP payment Have tried, but unable to recruit Solo GP close to retirement Not sure what service a practice nurse could provide

Other (please specify)

Opening Hours: morning afternoon

Monday to to

Tuesday to to

Wednesday to to

Thursday to to

Opening Hours: morning afternoon

Friday to to

Saturday to to

Sunday to to

Public Holiday to to

Aged Care: Nursing Home Visits: Yes No If no, are you interested in visiting? Yes No

If yes, Number of GPs who visit nursing homes

By whom:

.....

If yes, Aged Care Facilities Visited:

.....

.....

Mental Health: ATAPS Yes No Level 1 Level 2 (FPS) **Immunisation:** GPII Registered Yes No **Data Transfer to ACIR:** Paper Medicare Online Secure Site **Do you receive GPII20A Report?** Yes No **Do you data cleanse GPII20A Report?** Yes No **Recall Systems:****Diabetes** Electronic Non-electronic **Cardiovascular Disease** Electronic Non-electronic **Asthma** Electronic Non-electronic **Pathology** Electronic Non-electronic **Radiology** Electronic Non-electronic **Immunisations** Electronic Non-electronic **Pap Smears** Electronic Non-electronic **Other** Electronic Non-electronic **Reminder Systems:****Diabetes** Electronic Non-electronic **Cardiovascular Disease** Electronic Non-electronic **Asthma** Electronic Non-electronic **Pathology** Electronic Non-electronic **Radiology** Electronic Non-electronic **Immunisations** Electronic Non-electronic **Pap Smears** Electronic Non-electronic **Other** Electronic Non-electronic **Patient Records:** Paper-based Computer-based Combination **Clinical Software:** MD2 MD3 Best Practice Other (please specify)**Medicare Billing:** Easy Claim Medicare Online Paper Bulkbilling Private billing Gap **Internet:** Broadband Dial Up No Internet **Electronic Data Transfer:** Radiology Pathology Correspondence Other **Cervical Screening:** Registered with Pap Register: Yes No **Vaccine:** Vaccine Fridge Domestic Bar Fridge **Does the practice have disabled parking?** Yes No **Is the practice accessible by wheelchair?** Yes No **Is your practice within 200m of:** Bus stop Train Station Taxi Stand **Secondary Practice Address:**

Practice Name:

Physical Address:

Telephone:

Fax:

Email:

Hours you work at this practice per week:

Full Members are required to:

Be a general practitioner in practice principally in the Bankstown Local Government Area.

Pay an annual subscription fee of **\$132.00** (GST inclusive).

Show proof of current NSW Medical Board Registration (copy of current membership card to be attached).

Associate Members are required to:

Be a general practitioner who works outside the Bankstown LGA, all other medical practitioners (including, but not limited to RMOs, medical and surgical specialists, medical students, Allied Health Professionals, staff specialists, visiting medical officers, retired doctors, practice staff and others who do not fulfil the criteria for full membership or registrar membership.

Associate Members are eligible to attend meetings of the Division, however, do not have voting rights.

Pay an annual subscription fee of **\$105.60** (GST inclusive).

Show proof, where relevant of current NSW Medical Board Registration or other registration with appropriate professional bodies (copies of documents to be attached) i.e. Australian Psychological Society.

Registrar Members are required to:

Be a registrar on the GP Synergy Program.

Registrar Members will automatically cease to be members on the expiration of their term on this training program.

Registrar Members are eligible to attend meetings of the Division, however, do not have voting rights.

No membership fee will be levied.

Show proof of admission to the GP Synergy Program (include paperwork which confirms current status with GP Synergy and registration number on the Program and **show proof** of current NSW Medical Board Registration (copy with application).

Shared Information:

As part of the Division's aim to improve communication between GPs and Area and Local Health sectors i.e. Sydney South West Area Health Service (SSWAHS) and Bankstown Health Service (BHS), respectively, and to ensure that these Services have accurate information, your PROFESSIONAL AND CONTACT DETAILS (excluding your provider number) will be shared with these Services. If you do NOT wish to share your information with these Services, please tick the box below. A copy of the Division's Privacy Statement is enclosed with this form.

I do **NOT** wish to share my details

Declaration:

I declare that all information supplied in this Form for Membership is true and correct and that I have included copies, as proof, of my current documents.

I also undertake and accept that it is my responsibility to notify the Division in writing within seven (7) days of any changes to this information that would affect my eligibility for Membership including notification of the cancellation of and/or restrictions on my NSW Medical Board Registration.

I also understand that my professional and contact details (excluding provider number) will be shared with Area and Local Health Services i.e. SSWAHS and BHS, unless otherwise specified above.

Name: _____

Signature: _____ Date: _____

Please return signed Membership Form with the applicable payment and copies of the relevant proof documents in the reply paid envelope.

Payment can be made by cheque or bank transfer:-

Account Name: Bankstown GP Division Inc

Bank Name: Commonwealth Bank of Australia

BSB Number: 062 141

Account Number: 2800 0273

Reference: invoice number

For Division Office use only

Date received _____ Receipt No. _____

Entered Data Base