Corporate Membership application

Please note: This is a tax invoice once payment has been receipted

Business Details

Pharmacy Name: ..... ABN: ..... Phone: .....

Preferred mailing address: ..... Suburb: .....

State: ..... Post code: ..... Email address: .....

Membership Details - *(All 5 members must be employed by the business)*

Nominee 1 *(Designated nominee who holds voting rights)*

Title: ..... Last name: ..... Given name(s): ..... Position: .....

Nominee 2

Title: ..... Last name: ..... Given name(s): ..... Position: .....

Nominee 3

Title: ..... Last name: ..... Given name(s): ..... Position: .....

Nominee 4

Title: ..... Last name: ..... Given name(s): ..... Position: .....

Nominee 5

Title: ..... Last name: ..... Given name(s): ..... Position: .....

Additional information

Area of practice		Style of pharmacy (if applicable)	
☐ Community	☐ Government	☐ Regional Centre	☐ Strip
☐ Hospital	☐ Other	☐ Medical Centre	☐ Isolated
☐ Industry		☐ Neighbourhood	☐ Hospital

How did you hear about the College? ☐ Advertisement ☐ Friend or colleague ☐ Search engine ☐ Other: .....

Membership fee *(please tick)*

☐	**Corporate Membership** (Up to 5 nominees)	**$878.90** *inc $79.90 GST*

Payment options *(please tick)*

Please note: a surcharge of 2.5% will be charged on all card transactions

☐ **Credit Card** Visa Mastercard Amex

Card Number: ..... - ..... - ..... - ..... Total: .....

Cardholder's name: ..... Expiry date: ..... / .....

☐ **Direct Deposit** **College bank details:** Australian College of Pharmacy BSB: 082-057 Account: 858597370

Full name: ..... Date of payment: .....

☐ **Cheque** – cheques made out to Australian College of Pharmacy

Declaration

☐ I have read and understood the College's Privacy Policy, Terms and Conditions and Refund Policy. I declare that the information provided on this form is correct.

PO Box 493, Fyshwick ACT 2609
Email: info@acp.edu.au Tel: 02 6188 4320 Fax: 02 6273 8988
ABN: 44 008 588 841

Corporate Membership application

For each of the (up to 5) owner/employees of the corporate member business

Personal Details	Nominee 1 *(Designated nominee who holds voting rights)*	Nominee 2	Nominee 3	Nominee 4	Nominee 5
Last Name					
Given Name (s)					
Preferred Mailing Address					
Suburb					
State					
Postcode					
Home Phone					
Mobile Phone					
Email Address					
Date of Birth ***(we need your DOB to ensure security of your account)***					
Pharmacist/Non Pharmacist					
Post Nominals *(if applicable)*					
Other Memberships Held *(Eg. PSA, Guild, SHPA, AACP)*					
Declaration **(please tick)** I declare that the information provided on this form is correct.					

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