

CATEGORY OF MEMBERSHIP (Please select one)

<input type="checkbox"/>	Full Membership	<input type="checkbox"/>	Affiliate Membership
<input type="checkbox"/>	Associate Membership	<input type="checkbox"/>	Retired Membership

DEMOGRAPHICS AND PERSONAL DETAILS

Title:		First Name:	
Surname:		Other/middle names:	
Date of birth:		Gender	
Mailing address:			
State/Region/Island:		Post Code:	
Email address:			
Phone Number:		RACS Fellowship ID	

PROFESSIONAL DETAILS

Primary position:			
Institution:			
Unit:			
Year commenced Consultant Practice			

PUBLIC HOSPITALS

Status of Appointment:	<input type="checkbox"/>	Academic	<input type="checkbox"/>	VMO	<input type="checkbox"/>	Staff	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Unit type:	<input type="checkbox"/>	General	<input type="checkbox"/>	Breast	<input type="checkbox"/>	Plastics	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Position in Unit	<input type="checkbox"/>	Head	<input type="checkbox"/>	Deputy	<input type="checkbox"/>	Member	<input type="checkbox"/>	Other	<input type="checkbox"/>

PRIVATE HOSPITALS

Status of Appointment:	<input type="checkbox"/>	Academic	<input type="checkbox"/>	VMO	<input type="checkbox"/>	Staff	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Unit type:	<input type="checkbox"/>	General	<input type="checkbox"/>	Breast	<input type="checkbox"/>	Plastics	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Position in Unit	<input type="checkbox"/>	Head	<input type="checkbox"/>	Deputy	<input type="checkbox"/>	Member	<input type="checkbox"/>	Other	<input type="checkbox"/>

QUALIFICATIONS: please indicate Degrees, Diplomas, FRACS and other Affiliations

Year Awarded	Qualification	Awarding Institution

BREAST FELLOWSHIP

	Year commenced	Institution	Country
Year 1			
Year 2			
Year 3			

Date completed:

Breast Surgery Presentations/Honours/Prizes (please provide details for previous five (5) years only)

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CONTINUING PROFESSIONAL DEVELOPMENT (Breast Surgery)

Please provide details of any national or international breast specific workshops, conferences, or educational events attended in the past five (5) years

BreastSurgANZ Level 1 Oncoplastic Breast Surgery Workshop	Yes	No	Year
BreastSurgANZ Level 2 Oncoplastic Breast Surgery Workshop	Yes	No	Year

OTHER (Please Specify)

Workshop/Conference	Year attended

BREAST QUALITY AUDIT

To be completed by existing Associate members only

Please detail the number of cases you have contributed to the BQA for the past three years

YEAR		Number of cases		YEAR		Number of cases		YEAR		Number of cases	
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REFEREES:

(Please ensure you attach two (2) letters of support from your referees who must be full financial BreastSurgANZ members. Letters should be addressed to the Executive General Manager, BreastSurgANZ. Email references are not accepted)

REFEREE 1

Name:		Position:	
Email:		Contact no.:	

REFEREE 2

Name:		Position:	
Email:		Contact no.:	

DECLARATION BY APPLICANTS

I wish to apply for membership of Breast Surgeons of Australia and New Zealand Incorporated (*BreastSurgANZ*) and agree to be bound by the Articles of Association of the Society. I acknowledge I have read the current BreastSurgANZ Membership Policy and agree to comply with the requirements of Membership as summarised below:

- Maintain current registration as a specialist in my health jurisdiction
- Maintain registration as a specialist Surgeon to RACS or international RACS equivalent, and to notify the Society immediately if your medical registration is suspended or cancelled
- Undertake full involvement in and compliance with the BreastSurgANZ Breast Quality Audit (BQA) processes and standards in the Membership policy as applicable to your membership category
- Provide evidence (if requested) of Continuing Medical Education in breast disease, including attending a related meeting every two (2) years
- Adhere to the [BreastSurgANZ Code of Conduct](#).
- Ensure payment of your annual fee for membership. As per the BreastSurgANZ Constitution memberships will be suspended following 12 months of non-payment and membership will be terminated if membership remains unpaid for 24 months.

Please ensure you have read the [BreastSurgANZ Constitution](#) and [Membership Policy](#) before submitting your application. By submitting and signing this application you are consenting to be bound by the BreastSurgANZ Constitution and the rules associated with membership of the Society.

Signature:		Date:	
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APPLICATION SUBMISSION

Please submit the BreastSurgANZ Membership Application Form together with:

- a **current CV**, and
- the written references from two current, full, financial BreastSurgANZ members

Please return your membership application to the Chief Executive Officer (CEO), BreastSurgANZ via email at E: enquiries@breastsurganz.org

APPLICATION PROCESS

Completed applications will be considered by the Society's Membership Committee at the first meeting following receipt of all required paperwork in accordance with the Terms of Reference approved by Council.

All decisions of the Membership Committee must be reviewed and endorsed by the BreastSurgANZ Council.

You may be asked for additional information in support of your application and will be notified of the outcome as soon as possible.

Successful applicants will be invoiced for full or pro-rata membership fees for the whichever membership year the application is made.

To avoid delay in processing of applications, please ensure all information is provided at the time of submission.

Please email enquiries@breastsurganz.org should you have any queries or require any further information about this process.