

CATEGORY OF MEMBERSHIP (Please select one)

<input type="checkbox"/>	Full Membership	<input type="checkbox"/>	Associate Membership	<input type="checkbox"/>	Affiliate (non-operative)
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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			
Medical Registration Number					
Do you currently have any restrictions on your scope of practice? Please tick		YES		NO	
If you answered YES above, please provide details					

PROFESSIONAL DETAILS

Primary position:					
Institution:					
Unit:					
Year commenced Consultant Practice					

HOSPITAL APPOINTMENT

Status of Appointment:		Consultant Surgeon <small>Please tick</small>		Other <small>Please specify</small>			
Unit type: <small>Please tick</small>		General		Breast		Plastics	
Position in Unit <small>Please tick</small>		Head		Deputy		Member	
						Other <small>Please specify</small>	

Please describe your current breast surgical practice *(please add additional pages if you are unable to complete all information below)*

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)						

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	<input type="checkbox"/>	Yes	Year	<input type="checkbox"/>	<input type="checkbox"/>	No
BreastSurgANZ Level 2 Oncoplastic Breast Surgery Workshop	<input type="checkbox"/>	Yes	Year	<input type="checkbox"/>	<input type="checkbox"/>	No
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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BreastScreen involvement Please tick	Weekly		Fortnightly		Monthly	
MDM attendance Please tick	Weekly		Fortnightly		Monthly	

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 CEO, 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 Constitution 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,
- 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 18 months.

In submitting this application, I confirm that I have current registration with AHPRA and/or the Medical Council New Zealand (MCNZ) and have no restrictions imposed on my practice.

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 refer to the BreastSurgANZ Membership Policy for details of application submission.

Please return your membership application to the Chief Executive Officer (CEO), BreastSurgANZ via email at E: admin@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 admin@breastsurganz.org should you have any queries or require any further information about this process.