BREAST SURGEONS of Australia & New Zealand

MEMBERSHIP APPLICATION FORM

CATEGORY OF MEMBERSHIP (Please select one)

☐	Full Membership	☐	Associate Membership	☐	Affiliate (non-operative)
☐	Associate to Full 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	
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 Please tick		Other Please specify			
Unit type: Please tick	☐	General	☐	Breast	☐	Plastics	☐	Other Please specify	
Position in Unit Please tick	☐	Head	☐	Deputy	☐	Member	☐	Other Please specify	

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

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 and BreastSurgANZ Constitution 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:**	

STATEMENT OF BREAST SURGICAL PRACTICE

Statement of current breast practice (should include details pertaining to breadth, scope and length of current practice, including involvement in MDM, BreastScreen, clinical trials and research

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 the 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.