



AOTP Inc.
PO Box 606
Subiaco
WA 6904

The Association of Operating Theatre Practitioners Inc.

Formerly the Western Australian Society of Anaesthesia Technicians Inc

Visit our website: www.aotp.org.au

INVITES YOU TO RENEW YOUR MEMBERSHIP OR JOIN US FOR THE FINANCIAL YEAR

1 July 2011 to 30 June 2012

Please fill in the following information to assist in maintaining the AOTP Inc database. All data is confidential and only released with your written consent.

Full Name: _____
(Surname) (First Name) (Middle Name)

Home Address: _____ Post Code _____

Postal Address: _____ Post Code _____

Email Address: _____

Contact Details: Home Phone () _____ Mobile _____

Date of Birth: _____ Membership Number (If known) _____

Hospital/Company Employed at: _____ Occupational Title _____

Hospital/ Company Address: _____ Post Code _____

Public or Private: _____ Work Phone No: () _____

Anaesthetic Qualification Held: _____

PLEASE NOTE: For all new registrations to please attach copy of qualification.

State or Country Passed: _____ Date Qualification Obtained _____

Other Qualifications: _____

Membership Status Applying for:

Tick Box

Ordinary Payment may be claimed for Taxation Purposes	\$50.00	<input type="checkbox"/>
Associate Payment may be claimed for Taxation Purposes	\$50.00	<input type="checkbox"/>
Student Anaesthesia Technician	FREE	<input type="checkbox"/>
Corporate Payment may be claimed for Taxation Purposes	\$70.00	<input type="checkbox"/>
New Members Please add \$5.00 New Membership Administration Fee (Students are exempt) New registrations will not be processed without attached qualification documentation	\$5.00	<input type="checkbox"/>
Existing Members renewing after 1st of September please add \$5.00 Admin Fee Payment may be claimed for Taxation Purposes	\$5.00	<input type="checkbox"/>

Please do not send cash in the Post

Enter Total Remittance in AUD\$

Please Sign Here: _____ Date: _____

For credit card payments, please use the credit card authorisation form **Please make cheques payable to AOTP Inc.**

Thank you for supporting AOTP Inc.

ONE-TIME USE CREDIT CARD AUTHORISATION FORM

Amount to be charged: \$ _____

Credit Card: MASTERCARD / VISA (Please circle one)

Credit Card Number: _____

Expiration Date: _____ / _____ / _____

CCV (last 3 Digit on Back of Card) _____

Cardholders Name: _____

Signature: _____

Date _____

MAIL TO

AOTP Inc.
P.O. Box 606
Subiaco
WA 6904

OR E-MAIL

brenda.borton@health.wa.gov.au

For office use only:

Cash _____

Cheque _____

MasterCard _____

Visa _____

Receipt No. _____