APPLICATION FOR MEMBERSHIP

FIJI MEDICAL ASSOCIATION
304 Waimanu Road,
Cnr of Browne St & Amy St, Suva
GPO Box 1116, SUVA
Tel / fax (679) 3315 388
Email: fma@unwired.com.fi

Please print all names in full:
I

Being a Medical Practitioner registered in Part II of the Medical Register of Fiji; apply to become a member of the **Fiji Medical Association**

Professional Data: Academic Qualification(s)	University/ College	Date Obtained
Membership of other Professional societies		
Date of Entry to Part II of Register		
Date of Entry to Specialist Register (if relevant)		
Location of Workplace:		Salaried/Self-employed/Retired
Type of Practice/Position Held		Full/Part-time/ Retired
Contract officers only: from:	___/___/___.	Until ___/___/___.

Declaration: I agree to abide by the Rules and Code of Ethics of the Association, and to pay the full annual Subscriptions of the association.

I will pay subscriptions:

☐ Annually by cheque/cash; OR ☐ Regular salary deduction E.D.P. NO._____

Signature: _____ Date: _____/_____/_____

Contact Address: Postal, telephone, Fax, e-mail:

Postal: _____ Phone Work: _____

_____ Home: _____

E-mail: _____ Fax: _____

Office Use Only
Registration status confirmed (by Secretary, Fiji Media Council) Yes/ No, Reg. No _____
First annual subscription received: Receipt No: _____ Dates covered: _____
OR salary deduction commenced on: Date: _____ Pay Run: _____
Rules, card sent to Applicant (date) _____

MEMBERSHIP NUMBER: ☐

MEMBERSHIP APPLICATION AUTHORITY FORM

304 Waimanu Road,
Cnr of Browne St & Amy St, Suva
GPO Box 1116, SUVA
Tel / fax (679) 3315 388
Email: fma@unwired.com.fj

STATION: …….

I…… EDP No: ……
(Full Name)
Hereby authorizes you to deduct from my salary/wages $.....per fortnight being the amount of my association subscription (or such lesser or greater sum as may subsequently be prescribed as the subscription rate by any amendment to the Association Constitution). Such sum to be paid to the National Treasurer, Fiji Medical Association, whose receipt shall be sufficient discharge. This deduction from my salary/wages shall commence as soon as possible after the date that this application/authority form is signed.

Financial Year: July 1st – June 30th Note Annual Subscription: F$260.00
Fortnightly Deduction: $10 plus arrears (if relevant)

…… ……
(Date) (Members Signature)

…….....
(Treasurer FMA)

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(Date) (Members Signature)

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(Treasurer FMA)