



**The Royal Australian and New Zealand
College of Ophthalmologists**

A.C.N: 000 644 404

**Application for Associate Membership
as an
Ophthalmic Practice Manager**

Title:

Name:
(surname) **PLEASE PRINT** (given names)

D.O.B:/...../.....

Mailing Address for Membership matters:

.....

.....Post Code:

Telephone: (Work)..... (Home) (Mobile)

Email:

I am an Ophthalmic Practice Manager with Dr

PRACTICE ADDRESS:

.....

Phone: Fax: E-mail:

I AGREE TO ABIDE BY CONSTITUTION AND ANY RULES AND REGULATIONS OF THE
ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF OPHTHALMOLOGISTS.

Signature: Date:/...../.....

Return to:
The Royal Australian and New Zealand College of Ophthalmologists
94-98 Chalmers Street
Surry Hills NSW 2010

TAX INVOICE

A.B.N: 80 000 644 404

Member category: Practice Manager\$99.00 (GST Inclusive)

METHODS OF PAYMENT

Please tick your method of payment:

1. Credit Card

Visa Bankcard Mastercard

Card Account Number

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Cardholder's Name Expiry Date ___/___

2. Cheque Please make cheque payable to RANZCO

Please return your completed application with payment to:

The RANZCO
94-98 Chalmers Street
SURRY HILLS NSW 2010
AUSTRALIA

OR

Fax your completed application with Credit Card payment to:
61-2 9690 1321

Direct inquiries to:

Phone: 02 9690 1001
E-mail: margdunn@ranzco.edu

Signature (if sending by post)