

COSMETIC PHYSICIANS SOCIETY OF AUSTRALASIA INC

ABN 12 832 543 821

APPLICATION FOR FULL MEMBERSHIP



UPGRADING TO A FULL MEMBER

- An Associate member must resubmit an application form with nominator and seconder to upgrade to a Full member, along with current registration details and current insurance status.
- The rules require that a letter to the president be sent justifying the request for elevation of status i.e. explaining the advancement of skills achieved since joining.
- All courses attended and members worked with should be listed.
- At least two Full members must be able to vouch for the Associate to say that they are competent in at least one area of cosmetic medicine and they should sign as nominator and seconder on the application form.
- Insurance appropriateness should be rechecked.
- If there is any doubt a member of the Board, Advisory Panel or other appointed member can conduct an audit on the Associate.
- The Full member fee is \$750 (GST included).
- Listing on the website, voting rights and use of the Society name now become a right of membership, provided fees are kept up to date.

APPLICANTS FULL NAME								
Surname/Family Name:								
First Name:					Middle Name:			
POSTAL ADDRESS (For CPSA Correspondence [& Journals- Applicable Memberships Only])								
Postal Address:								
		Post Code:						
EMAIL AND WEB ADDRESS (Please note that email is the main form of communication, therefore a valid email address is essential [it is your responsibility to notify CPSA of any changes]. Please tick box for preferred email								
<input type="checkbox"/> Business Email:					<input type="checkbox"/> Home Email:			
Web Address:								
CONTACT TELEPHONE/FAX								
Business Ph:					Home Ph:			
Business Mobile:					Private Mobile:			
Business Fax:					Home Fax:			
PRINCIPAL PRACTICE ADDRESS								
Practice Address:								
		Post Code:						
CURRENT REGISTRATION (please tick appropriate box/boxes and enter registration number/s)								
State Territory	Registration Number	State Territory	Registration Number	State Territory	Registration Number	Country	Registration Number	
<input type="checkbox"/> QLD		<input type="checkbox"/> ACT		<input type="checkbox"/> SA		<input type="checkbox"/> CHINA		
<input type="checkbox"/> NSW		<input type="checkbox"/> NT		<input type="checkbox"/> WA		<input type="checkbox"/> SINGAPORE		
<input type="checkbox"/> VIC		<input type="checkbox"/> TAS		<input type="checkbox"/> NZ		<input type="checkbox"/> OTHER:		

President: Dr Gabrielle Caswell Ph: Australia (02) 6752 1333
 Secretary: (acting) Dr Peta Mayston Ph: Australia (07) 4779 5111
 Treasurer: Dr Tony Bartone Ph: Australia (03) 9826 6200
 Public Rel: Dr Jan Knight Ph: Australia (02) 9968 2600

All Correspondence To:
 4 Dardanus Way
 HEATHRIDGE WA 6027
 AUSTRALIA
 Ph: 1300 552 127

Accounts and Admin: Ph: Australia (08) 6201 6173
 Accounts and Admin Fx: Australia (08) 9402 4820
 Accounts and Admin Email: cpsa@iinet.net.au

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CURRENT PROVIDER NUMBER (a valid provider number must be held to upgrade to Full Membership of CPSA)

Yes, I do hold a valid provider number allowing for referrals to be written and pathology requested

MEDICAL INDEMNITY INSURANCE STATUS

Which Medical Defence Organisation (MDO) are you covered by?	Name of MDO:		
What level of coverage do you have?	Category of Practice:		
Medical Defence Organisation Membership Number:			
<input type="checkbox"/> Yes, I do give permission to check insurance details		Signed:	
Do you have additional procedures added to your policy?	Added Procedures:		

COSMETIC PROCEDURES CURRENTLY PERFORMED (tick if performed)

Procedure	Performed	Procedure	Performed
<i>Abdominoplasty</i>	<input type="checkbox"/>	<i>Laser Removal of Pigmented Lesions</i>	<input type="checkbox"/>
<i>Anti-ageing Hormonal Treatment</i>	<input type="checkbox"/>	<i>Laser Removal of Vascular Lesions</i>	<input type="checkbox"/>
<i>Aptos Threads/Contour Threads</i>	<input type="checkbox"/>	<i>Laser Resurfacing (Erbium/CO2)</i>	<input type="checkbox"/>
<i>Aquamid Injections</i>	<input type="checkbox"/>	<i>Laser Tattoo Removal</i>	<input type="checkbox"/>
<i>Blepharoplasty (using Laser)</i>	<input type="checkbox"/>	<i>Lipectomy</i>	<input type="checkbox"/>
<i>Blepharoplasty (using Scalpel)</i>	<input type="checkbox"/>	<i>Lipo-Dissolving Treatments (injection lipolysis)</i>	<input type="checkbox"/>
<i>Breast Augmentation</i>	<input type="checkbox"/>	<i>Liposuction (< 2 litres fat extracted)</i>	<input type="checkbox"/>
<i>Breast Lift - Maxtopexy</i>	<input type="checkbox"/>	<i>Liposuction (>2 litres < 5 litres fat extracted)</i>	<input type="checkbox"/>
<i>Breast Reduction</i>	<input type="checkbox"/>	<i>Liposuction (> 5 litres fat extracted)</i>	<input type="checkbox"/>
<i>Botulinum Toxin Injections</i>	<input type="checkbox"/>	<i>Mesotherapy</i>	<input type="checkbox"/>
<i>Chemical Peels - superficial</i>	<input type="checkbox"/>	<i>Microdermabrasion</i>	<input type="checkbox"/>
<i>Chemical Peels – medium depth</i>	<input type="checkbox"/>	<i>Microneedle Therapy (roll CIT)</i>	<input type="checkbox"/>
<i>Chemical Peels - deep</i>	<input type="checkbox"/>	<i>Minor Excisions</i>	<input type="checkbox"/>
<i>Collagen Injections</i>	<input type="checkbox"/>	<i>Otoplasty - Cosmetic</i>	<input type="checkbox"/>
<i>Dermabrasion</i>	<input type="checkbox"/>	<i>Photodynamic Therapy (PDT)</i>	<input type="checkbox"/>
<i>Endovenous Laser Treatment (EVLT)</i>	<input type="checkbox"/>	<i>Plasma Skin Regeneration (PSR) Portrait</i>	<input type="checkbox"/>
<i>Face Lift</i>	<input type="checkbox"/>	<i>PUVA and UVB Treatment</i>	<input type="checkbox"/>
<i>Fat Injections (non breast)</i>	<input type="checkbox"/>	<i>Radiesse Injections</i>	<input type="checkbox"/>
<i>Fat Injections to Breast</i>	<input type="checkbox"/>	<i>Restylane Sub Q Injections</i>	<input type="checkbox"/>
<i>Fat Reduction (eg Ultrashape, Accent)</i>	<input type="checkbox"/>	<i>Rhinoplasty - Cosmetic</i>	<input type="checkbox"/>
<i>Fractional Resurfacing (eg Fraxel Laser)</i>	<input type="checkbox"/>	<i>Sclerotherapy</i>	<input type="checkbox"/>
<i>Gortex Implants or similar</i>	<input type="checkbox"/>	<i>Sculptra Injections</i>	<input type="checkbox"/>
<i>Hair Transplants</i>	<input type="checkbox"/>	<i>Skin tightening - Bipolar RF (eg Elos)</i>	<input type="checkbox"/>
<i>Hyaluronic Acid Injections</i>	<input type="checkbox"/>	<i>Skin Tightening-Monopolar RF (eg Thermage)</i>	<input type="checkbox"/>
<i>Laser/IPL Hair Reduction</i>	<input type="checkbox"/>	<i>Skin Tightening – Other (eg Titan)</i>	<input type="checkbox"/>
<i>Laser/IPL Skin Rejuvenation</i>	<input type="checkbox"/>	<i>Stitch Lift/Saffe Lift</i>	<input type="checkbox"/>
<i>Other (please Specify):</i>	<input type="checkbox"/>	<i>Other (Please Specify):</i>	<input type="checkbox"/>

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APPLICATION FOR FULL MEMBERSHIP



APPLICANT'S DECLARATION

I hereby apply to become a member of the above-named Incorporated Association. In the event of my admission as a member, I agree to comply with the CPSA constitution and all its protocols, guidelines and policies, as well as all relevant state and federal laws and guidelines, including those administered by governments, medical boards and other organisations such as the Therapeutic Goods Administration, including those in relation to advertising. I also give my permission for the Association to seek information from other parties to verify my standing, in particular Medical Defence Organisations and Medical Boards.

Signed:		Date:	
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NOMINEE AND SECONDER

We, Full, financial, members of the Association, nominate and second the application of this person who is personally known to us, for membership of the Association.

Nominee: (print name in full)			
Signature:		Date:	
Secunder: (print name in full)			
Signature:		Date:	

PLEASE ENSURE THAT ALL OF THE FOLLOWING ARE INCLUDED WITH YOUR UPDATED APPLICATION
(Please note that your application must be signed and completed in order to be processed - check each box and send, either by mail, Fax or email to the address below)

<input type="checkbox"/>	Signed and completed form (3 pages)
<input type="checkbox"/>	Copy of current registration form/ annual practising certificate
<input type="checkbox"/>	Copy of current Medical Indemnity Fund Membership - showing level of cover (details may be checked to ensure that all our members have adequate cover)
<input type="checkbox"/>	Copy of Curriculum Vitae
<input type="checkbox"/>	Payment by: <input type="checkbox"/> cheque; <input type="checkbox"/> bank draft; <input type="checkbox"/> credit card; <input type="checkbox"/> direct debit; - membership(NB: All fees are GST inclusive): Application for Full Membership can only be applied for, after being an Associate Member for one year. Full Membership \$750.

Payment by Credit Card (Visa, Mastercard)	(not Amex or Diners) Call 1300 552 127 Monday to Friday 9am to 5pm (WA time) Please note paid by credit card below with date and amount paid.
Payment by Direct Debit - Electronic Funds Transfer (EFT)	Pay to Cosmetic Physicians Society National Account (NAB) BSB 086-420 Account 863881675 Please note EFT receipt number below as well as amount transferred and date.
Payment by Personal Cheque or Bank Draft (Australian Dollars)	Make cheque payable to: 'Cosmetic Physicians Society of Australasia Inc', and post to: 4 Dardanus Way, HEATHRIDGE WA 6027, AUSTRALIA Please note cheque number below as well as amount and date.

You **MUST** complete advice of your payment below:

Once application and payment is completed:

Post to: 4 Dardanus Way
HEATHRIDGE WA 6027
AUSTRALIA

Fax to: (08) 9402 4820

Email to: cpsa@iinet.net.au

Paid by: <input type="checkbox"/> cheque <input type="checkbox"/> bank draft <input type="checkbox"/> direct debit <input type="checkbox"/> credit card			
Amount Paid:		Date:	
Cheque /EFT no.:			