

**Hearing Aid Audiology Society of Australia Ltd**

**Application for Membership**

*All fields are mandatory unless marked “optional”.*

**Personal**

|  |  |
| --- | --- |
| Title: First name: | Surname: |
| Male/Female Date of Birth: | Preferred name: |
| Home Address: |
| City: | State: Postcode: |
| Home Mailing Address: |
| City: | State: Postcode: |
| Home Phone No: | Mobile Phone No: |
| Home Email (HAASA uses this for communications) |

 **Work**

|  |
| --- |
| Work business name: |
| Work Address: |
| City: | State: Postcode: |
| Work Mailing Address: |
| City: | State: Postcode: |
| Work Phone No: |  |
| Work Email: |

**Preferred Mailing Address** *(please circle)*Home/Work

**Membership Categories**

|  |  |  |
| --- | --- | --- |
| I wish to apply for (please tick): | Full membership |  |
|  | Associate membership |  |
| *Application/joining fee applies:**Full/Associate members (except if existing Student member)* | Student membership |  |
| Affiliate membership |  |

|  |  |
| --- | --- |
| **Qualified Practitioner Number** (if applicable): |  |

**Academic Qualifications** (optional)

|  |  |  |
| --- | --- | --- |
| **Qualification** | **Institution** | **Completed Year** |
|  |  |  |

**Other Memberships**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| AcAud |  | ASA |  | Membership Level |  |

**Please Circle Yes or No**

|  |  |
| --- | --- |
| Have you been refused membership by another PPB? | Yes/No |
| Have you ever appeared before a peer review panel? | Yes/No |
| Have you ever had a criminal conviction recorded against you? If so, please provide details below | Yes/No |
|  |

**I have attached** *(please tick)*

|  |  |
| --- | --- |
| Proof of membership of other membership |  |
| Copy of last CPED report or statutory declaration |  |
| Copy of Diploma of Audiometry/equivalent qualification/academic transcript confirming entitlement to relevant qualification |  |
| Letter of employment (Associate membership applications only) |  |
| [Supervision Agreement](https://www.haasa.org.au/resources/Documents/Supervision%20Agreement.pdf) (Associate membership applications only) |  |

**Supervisor Details***(Associate or Student membership applications only)*

|  |  |  |
| --- | --- | --- |
| **Name** | **Phone No** | **Email** |
|  |  |  |

 **BUPA** *(Full membership applications only)*

I wish to be registered as a provider of services with BUPA Yes/No If yes, please provide clinic address:

|  |
| --- |
| Address: |
| City: | State: Postcode: |

 **Employment History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full/part time\*** | **Start/End Date** | **Position** | **Employer** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

\*If part time, please indicate number of hours working as an Audiometrist each week

**Declaration**

* I authorise HAASA to provide relevant membership information to the Hearing Services Program (as required by the provisions of the Memorandum of Understanding)
* I declare that the information above is accurate and true
* I acknowledge I may be required to substantiate the above information
* I have read and understand the Code of Conduct of Hearing Aid Audiology Society of Australia Ltd and agree to abide by it should my application be successful

|  |  |
| --- | --- |
| **Signed** | **Dated** |
|  |  |

Note: fees will be invoiced upon approval of application. Approvals may take up to 14 days.