Hearing Aid Audiology Society of Australia Limited
Application for Membership

www.haasa.org.au haasa@haasa.org.au

All fields are mandatory unless marked "optional"

Title: Name:	Surname:
Male/Female Date Of Birth:	Preferred Name:
Home Address:	
City:	State: Post Code:
A/Hours Telephone: (optional)	Mobile Telephone:
Home Email address:	
Work Address:	
City:	State: Post Code:
Work Telephone: (optional)	Fax: (optional)
Preferred Mailing Address:	
City:	State: Post Code:

Payment of Member Fees: **Please ensure you include your surname in the reference area**

Direct Bank transfer: HAASA LTD BSB: (CBA) 062-339 Account: 1102 1985

Pay by credit card Phone 0401 517 952 Note: we charge a payment fee of 2%

Membership Categories

I wish to apply for: (please tick)

- Full Member ☐
- Associate Member ☐
- Student Member ☐
- Affiliate Member ☐

Application/Joining fee: Full and Associate Member $230

Qualified Practitioner No:

Academic Qualifications (optional)

Qualification	Institution	Completed Year

Practitioner Professional Bodies

Current member of ACAUD ☐ ASA ☐ Membership Level

or other body (details please)

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 provide details below	Yes/ No

I have attached: (please tick)

Proof of Membership of PPB	☐
Copy of Last CPED Report or Statutory declaration	☐
a copy of my Certificate IV in Audiometry /Diploma of Hearing Device Prescription & Evaluation	☐
OR evidence of my enrolment in the above course;	☐
OR a copy of my academic transcript indicating I am entitled to a	☐
Diploma in Audiometry or equivalent.	☐

If you are applying for student or associate membership please identify the name of your supervisor(s).

Supervisor Name:	Contact telephone:
Contact Email:	
Supervisor Name:	Contact telephone:
Contact Email:	

Employment History

Full/Part time*	Start/End Date	Position	Employer

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

Overseas Applicants Must hold one of following. Proof required please.

Hearing Aid Dispensing Diploma ☐ Tertiary Qualifications in Audiology ☐

Member of Professional Association:

Declaration:

I authorise HAASA to provide relevant membership information to the Office of Hearing Services (as required by the provisions of the Memorandum of Understanding).

I declare that the above information is accurate and true.

I acknowledge I may be required to substantiate the information.

I have read and understand the Code of Conduct of Hearing Aid Audiology Society of Australia Limited and agree to abide by it should my application be successful.

Signed:	Date:

Hearing Aid Audiology Society of Australia Limited ABN 67 626 701 559

PO BOX 4305 GEELONG VIC 3220 Phone: 0401 517 952 Email: haasa@haasa.org.au