Membership Number: ☐

Australasian Health and Research Data Managers Association Incorporated

PO Box 2681
TAREN POINT NSW 2229
www.ahrdma.com.au

Membership Application Form / Invoice

ABN 61 644 545 082 (AHRDMA is not registered for GST)

Title: Miss / Mrs / Ms / Mr / Dr / Prof
Name: _____
Postal Address: _____
_____
_____
Email Address:** _____
Phone Number: _____
Fax Number: _____

**Receipt of advertisements, circulars and renewal advice will be emailed unless otherwise requested

AHRDMA values your privacy and does not give out information about you or your contact details to non members. We do however receive requests for information about our members in so far as interest groups and possible consultation. In the event you do not wish your details to be given, we ask you to complete the following:

Permission for work contact details to be given to other AHRDMA members?	☐ No
Permission to be contacted via phone or email by a Regional Convener?	☐ No
Permission to be contacted by organisations requesting consultation with AHRDMA members?	☐ No

Organisation: (tick the most relevant)
☐ Hospital / Medical Institution ☐ Academic Organisation ☐ Private Industry / CRO ☐ Other: _____

Work Areas: (tick all that apply)
☐ Clinical Trials ☐ Regulatory Issues ☐ Statistics ☐ Registries
☐ Ethics / Research Governance ☐ Databases ☐ Quality Assurance ☐ Other: _____

Role / Position: (tick most relevant)
☐ Research Nurse ☐ Study Coordinator ☐ Data Manager ☐ Project Manager
☐ Clinical Research Associate ☐ Information Technology ☐ Research Manager ☐ Other: _____

Research / Therapeutic Areas: (e.g. Cardiology, Oncology, Infectious Diseases, etc.)

Membership Payment Options – tick one – Annual Fee of $AU50.00

☐ **New Member** Nominator: _____
(Must be a current financial member of AHRDMA)

☐ **Renewal**

Payment Options

1. Cheque or Money Order ***- made payable to "AHRDMA"***

2. Electronic Bank Transfer ***- enter your full name in the account description field***
BSB 113-879 Account 118 418 138

3. Credit Card - please debit my credit card for $AU50.00
Name on Credit Card: _____
Signature: _____
Credit Card Type: Mastercard ☐ Visa ☐

Credit Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐
Expiry Date: ☐☐ / ☐☐

Mail to the AHRDMA Treasurer, GPO Box 2821, (Spring Street), Melbourne VIC 3001.
Member enquiries to the AHRDMA Secretary on (07) 3176 5054 or adam_stoneley@health.qld.gov.au.