

Address:
27 Valetta Road
Kidman park
South Australia 5025

Telephone:
(08) 8234 6369

Postal Address:
PO Box 219
Brooklyn Park
South Australia 5032



New Member Form

Personal Details

Title:	First Name:	Last Name:	D.O.B:
Organisation:		Profession:	
Business Address:			
Business Phone:		Business Fax:	
Business Website:			
Mailing Address:		Suburb:	
		State:	
		Postcode:	
Mobile:	Home Phone:		
Email:			
Preferred Contact:	<input type="checkbox"/> Business Address	<input type="checkbox"/> Email	<input type="checkbox"/> Home Address

Membership Directory:

- I would like to have my business information displayed in the SASMA Online Membership Directory

Declarations

I certify that the information supplied on and with this form is true and correct. I agree to abide by the SA Sports Medicine Association Code of Ethics.

Signature: _____ **Date:** _____

Membership

Australian Sports Medicine Federation (SA Branch) Inc.
ABN: 35 446 122 543

- 12 month SASMA Professional Membership \$225.00 (inc. GST)
- 12 month SASMA International Membership \$200.00 (inc. GST)
- 12 month SASMA Associate Membership \$135.00 (inc. GST)
- 12 month SASMA Recent Graduate Membership \$130.00 (inc GST)
- 12 month SASMA Student Membership \$55.00 (inc GST)
- 12 month SASMA Retired Membership \$55.00 (inc GST)

Joining fee for new members is \$20.00

New members are required to provide a copy of their qualifications with their membership application

Payment Method (Please tick)		
Credit Card <input type="checkbox"/> Direct Debit Annually* <input type="checkbox"/> Once off payment	<input type="checkbox"/> Direct Bank Deposit Account: Australian Sports Med Fed SA Branch Inc BSB: 015-214 Account No: 4014 50838 Message / Reference:	<input type="checkbox"/> Cheque To: Australian Sports Medicine Federation (SA Branch) Inc
<i>* By selecting direct debit, your credit card will be debited annually on the date of renewal until notified. Please complete Card Holder Details and page two of the membership form.</i>		
Card Holder Details	<input type="checkbox"/> Visa <input type="checkbox"/> Master card	
Card Holder Name:		
Card Number:		
CVV Number:		
Expiry Date: /	Signature:	

Request to Debiting amount to accounts by the direct debit system

I/we request and authorise South Australian Sports Medicine Association, until further notice, to arrange payment of my SASMA Membership as per details above, by debiting my savings/cheque/credit card account as described in the form above. I acknowledge that SASMA may terminate this request at any time by written or verbal notice and I must adopt an alternative method of payment.

Name and address of financial institution at which your account is held: _____

I _____ *Full Name* authorise, South Australian Sports Medicine Association to arrange for funds to be debited from my/our account at the Financial Institution identified above. This authority is to remain in force in accordance with the terms described in the Direct Debit Service Agreement.

I acknowledge that in signing this document in the space below that I have received a copy of the direct debit request and understand that this direct debit arrangement is governed by the terms described in the Direct Debit Service Agreement*

Signature _____ **Date:** _____

*To view the Direct Debit Service Agreement go to: <http://bit.ly/2rQQHdp>