

**Catholic Doctors Association  
of Victoria**

**Personal Information**

Title: \_\_\_\_\_ First name: \_\_\_\_\_ Surname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female

**Home Address:**

Street: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Work Address:**

Street: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Telephone: \_\_\_\_\_

Other contacts:

Mobile Telephone: \_\_\_\_\_

Facsimile: \_\_\_\_\_

e-mail: \_\_\_\_\_

(Please tick your preferred method for correspondence from CDAV)

**Membership category**

Ordinary Member (\$50 per annum)

Student Member (Full time only, Free)

Associate Member (\$50 per annum)

I have read the Constitution of the Association and agree to abide by it.

Signed by: \_\_\_\_\_ Date: \_\_\_\_\_

Nominated by: \_\_\_\_\_ Date: \_\_\_\_\_

(exisiting members only)

**Payment**

I enclose a cheque for \$ \_\_\_\_\_

Return by mail to CDAV Membership Secretary PO Box 615 Black Rock 3191.