



APPLICATION FOR MEMBERSHIP

All Correspondence to:
CCSA Membership.
P.O. Box 203
North Ryde. NSW. 1670
Ph: (02) 9887 5001
Fax: (02) 9887 5895
www.CCSofA.org.au

PERSONAL DETAILS

Surname:

Given name/s:

Date of birth: Sex: Male / Female (please circle)

Title: Mr / Mrs / Miss / Ms / Other (please circle):

PRIMARY ADDRESS

This is your preferred mailing address. Note that all correspondence will be forwarded to this address.

This is a HOME / WORK address (please circle)

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City / Town: State: Postcode:

Telephone: () Mobile:

Fax: () Email:

ALTERNATE ADDRESS

This is an alternate address which will be used if attempts to forward mail to you at your primary address fail.

This is a HOME / WORK address (please circle)

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City / Town: State: Postcode:

Telephone: () Mobile:

Fax: () Email:

RELEASE OF DETAILS**

I do not wish the Managing Committee of the CCSA to release my address details to organisations or companies approved by the Committee for distribution of relevant material, newsletters or advertising. I undertake to notify the CCSA in writing at such time as I wish to begin receiving advertising material.

Signature: Date:

*** Note: If this section is not completed, the nominee will receive all advertising material as approved by the Managing Committee of the CCSA.*

I wish to join the CCSA as an: (tick appropriate box)

Ordinary Member

Student Member

(Applications for student membership need to be accompanied by proof of current enrolment in a recognised HIM / Clinical Coder education course)

AGREEMENT

I understand that by joining the CCSA I agree to be bound by the Code of Ethics and Constitution of the Clinical Coders' Society of Australia Inc.

Signature: Date:

OFFICE USE ONLY

Date received:

Date approved by Board:

Registration Number: Receipt Number:

Membership Fee: Joining Fee:

Certificate / Badge sent:

Notes:

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