



THE AUSTRALIAN PODIATRY ASSOCIATION (WESTERN AUSTRALIA)

Incorporated in 1966 – Limited by Guarantee

ABN 89 008 700 721

STUDENT MEMBERSHIP APPLICATION

PERSONAL DETAILS

Name:

Street:

Suburb:

State:

Postcode:

Telephone Number (AH:)

Fax Number:

Mobile Number:

Email

Mailing address for all correspondence: **AS ABOVE** (please circle or complete below)

Suburb:

State:

Postcode:

Date and Place of Birth:

Training Institution: UWA / Other: _____

Year of Study: (1st) (2nd) (3rd) (4th) Please circle

Anticipated year of completion of Studies: _____

Training Institution Authority:

I hereby certify that

is a student enrolled in an approved Podiatry course of study in a fulltime capacity.

Name_____

Contact number_____

Signature_____

Declaration:

Should my application be accepted, I declare that, as a member of the Australian Podiatry Association (Western Australia), I will observe and abide by the terms and conditions of the Memorandum and Articles of the Association (which can be viewed at the association Office or website, together with the By-laws and Code of Ethics) and will conduct myself honourably in the manner befitting a member of the Association.

SIGNATURE_____ Date_____

NAME OF WITNESS_____ OCCUPATION_____