The Pharmacy Guild of Australia
South Australian Branch

12 / 202 Glen Osmond Road, FULLARTON SA 5063
Tel 08 8304 8300 • Fax 08 8333 1729
Email guildsa@sa.guild.org.au • Web www.guild.org.au

Application for Membership
COMPANY – FORM 4 (RULE 29)

Notes to consider when completing this form
1. All questions must be answered for your application to be processed. Please provide your email address, as this is our preferred method of contact. We may request further information if required prior to processing this application.
2. Please return your completed form to the Branch Office, by posting to; Reply Paid 84861, FULLARTON SA 5063; or fax 08 8333 1729.
3. Your application will be processed, invoiced for membership, and then ratified at the next meeting of the South Australian Branch Committee. Should you have any queries prior to this, please contact Member Services at the Branch Office on 08 8304 8300.

The Branch Director
South Australian Branch
The Pharmacy Guild of Australia

Company name:		ACN:	
Company street address:			
	Suburb:	State:	Postcode:
Company email:	Phone: ( )	Fax: ( )	
Company postal address *(if different)*:			
	Suburb:	State:	Postcode:

The company, being an employer and eligible for membership hereby applies for admission as a member of the The Pharmacy Guild of Australia. The company agrees upon admission and while a member of the Guild to be bound by the Constitution of the Guild and by Resolutions of the National Council and of the Branch Committee now or hereafter in force and to pay to the Guild all subscription levies or other money payable from time to time as a member of the Guild pursuant to such Constitution and Resolutions.

SIGNED for and on behalf of the company by those persons who are authorised under its Constitution to do so:

Director .... Secretary ....

Print Name Print Name

DETAILS OF DIRECTORS

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:	Surname:		
First name:	Middle name:	Preferred name:	
Male ☐ Female ☐ Date of birth:	Pharmacist: ☐ Yes ☐ No		
Private address:	Suburb:	State:	Postcode:
Private email:	Mobile phone:	Private phone: ( )	
I declare that I am ☐ / am not ☐ a Member of the Pharmacy Guild as a sole proprietor, of a partnership or a director of a company, which is a Member of the Guild.			

Signature:.. Date:

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:	Surname:		
First name:	Middle name:	Preferred name:	
Male ☐ Female ☐ Date of birth:	Pharmacist: ☐ Yes ☐ No		
Private address:	Suburb:	State:	Postcode:
Private email:	Mobile phone:	Private phone: ( )	
I declare that I am ☐ / am not ☐ a Member of the Pharmacy Guild as a sole proprietor, of a partnership or a director of a company, which is a Member of the Guild.			

Signature:.. Date:

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:	Surname:		
First name:	Middle name:	Preferred name:	
Male ☐ Female ☐ Date of birth:	Pharmacist: ☐ Yes ☐ No		
Private address:	Suburb:	State:	Postcode:
Private email:	Mobile phone:	Private phone: ( )	
I declare that I am ☐ / am not ☐ a Member of the Pharmacy Guild as a sole proprietor, of a partnership or a director of a company, which is a Member of the Guild.			

Signature:.. Date:

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:	Surname:		
First name:	Middle name:	Preferred name:	
Male ☐ Female ☐ Date of birth:	Pharmacist: ☐ Yes ☐ No		
Private address:	Suburb:	State:	Postcode:
Private email:	Mobile phone:	Private phone: ( )	
I declare that I am ☐ / am not ☐ a Member of the Pharmacy Guild as a sole proprietor, of a partnership or a director of a company, which is a Member of the Guild.			

Signature:.. Date:

OFFICE USE

Membership #:	Letter sent: / / 20	Inv amount:	Entered:	
Invoice #:	Inv date: / / 20	$	☐ GEMM / / 20	☐ MYOB / / 20

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DETAILS OF DIRECTORS (continued).......

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:	Surname:	
First name:	Middle name:	Preferred name:
Male ☐ Female ☐ Date of birth:	Pharmacist: ☐ Yes ☐ No	
Private address:	Suburb:	State: Postcode:
Private email:	Mobile phone:	Private phone: ( )
I declare that I am ☐ / am not ☐ a Member of the Pharmacy Guild as a sole proprietor, of a partnership or a director of a company, which is a Member of the Guild.		

Signature:.. Date:

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:	Surname:	
First name:	Middle name:	Preferred name:
Male ☐ Female ☐ Date of birth:	Pharmacist: ☐ Yes ☐ No	
Private address:	Suburb:	State: Postcode:
Private email:	Mobile phone:	Private phone: ( )
I declare that I am ☐ / am not ☐ a Member of the Pharmacy Guild as a sole proprietor, of a partnership or a director of a company, which is a Member of the Guild.		

Signature:.. Date: *(if more, please attach separate list)*

DETAILS OF PHARMACY APPLYING FOR MEMBERSHIP

Pharmacy name:		PBS Approval #:	
Pharmacy street address:			
	Suburb:	State:	Postcode:
Pharmacy email:	Phone: ( )	Fax: ( )	
Banner name:	Marketing group:	Date pharmacy purchased / opened:	
Pharmacy postal name & address *(if different)*:			
	Suburb:	State:	Postcode:
Banner name:	Marketing group:	Date pharmacy purchased / opened:	
Is this a new pharmacy or has it been acquired? ☐ New ☐ Acquired	If acquired, please state name/s of previous owner/s:		

STATUTORY DECLARATION

We, the above directors, of the addresses set out above DO SOLEMNLY AND SINCERELY DECLARE:

1. We are all of the directors of the applicant company and more than one half of us are pharmacists (or in the case of a company having only two directors, one of us is a pharmacist), namely:
   ....
   ....
   ....
2. A majority of the issued voting shares in the company are beneficially owned by pharmacists, namely:
   ....
   ....
   ....
3. The company complies with the relevant legislation governing ownership and control of pharmacies in the State or Territory in which it carries on business.
4. **DETAILS OF OTHER PHARMACIES OWNED BY THE APPLICANT COMPANY OR IN WHICH THE COMPANY HAS A PROPRIETORY, LEGAL OR BENEFICIAL INTEREST.**

Pharmacy name:		**Suburb:**
Prop 1:	Prop 2:	Prop 3:
Prop 4:	Prop 5:	Prop 6:
Pharmacy name:		**Suburb:**
Prop 1:	Prop 2:	Prop 3:
Prop 4:	Prop 5:	Prop 6:
Pharmacy name:		**Suburb:**
Prop 1:	Prop 2:	Prop 3:
Prop 4:	Prop 5:	Prop 6:
Pharmacy name:		**Suburb:**
Prop 1:	Prop 2:	Prop 3:
Prop 4:	Prop 5:	Prop 6:
Pharmacy name:		**Suburb:**
Prop 1:	Prop 2:	Prop 3:
Prop 4:	Prop 5:	Prop 6:

(if more, please attach separate list)

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5. **DETAILS OF OTHER PHARMACIES OWNED EITHER INDIVIDUALLY OR AS A PARTNER IN A PARTNERSHIP BY ANY OF THE APPLICANT DIRECTOR/S**

Pharmacy name:		**Suburb:**
Prop 1:	Prop 2:	Prop 3:
Prop 4:	Prop 5:	Prop 6:
Pharmacy name:		**Suburb:**
Prop 1:	Prop 2:	Prop 3:
Prop 4:	Prop 5:	Prop 6:
Pharmacy name:		**Suburb:**
Prop 1:	Prop 2:	Prop 3:
Prop 4:	Prop 5:	Prop 6:
Pharmacy name:		**Suburb:**
Prop 1:	Prop 2:	Prop 3:
Prop 4:	Prop 5:	Prop 6:
Pharmacy name:		**Suburb:**
Prop 1:	Prop 2:	Prop 3:
Prop 4:	Prop 5:	Prop 6:
Pharmacy name:		**Suburb:**
Prop 1:	Prop 2:	Prop 3:
Prop 4:	Prop 5:	Prop 6:

(if more, please attach separate list)

6. We further agree to furnish in writing any further particulars in relation to this application upon request of the Branch Director.

Under the provisions of the Guild Constitution, members are required to register all proprietors in their pharmacy and all pharmacies in which they have an interest. All members must adhere to this obligation. Future changes should be notified by completing an *Application to Update Membership Status form*, available from http://www.guild.org.au/sa

We agree to furnish in writing, any further particulars in relation to this application upon request of the Branch Director.

Note: Where the applicant wishes to appoint a nominee under Rule 7 (b)(i), Form 13 (attached) should be completed at the same time as this membership form and lodged with the Branch Director.

And I make this solemn declaration by virtue of the relevant legislation governing Statutory Declarations and subject to the penalties provided by that legislation for making of false statements and statutory declarations, conscientiously believing the statements contained in this declaration to be true in every particular.

DECLARED AT ....) ....
)
THIS .... DAY OF) Before me

.... 20............) ....
A person Duly Authorised To Witness Statutory Declarations

PRIVACY NOTICE
By lodging this form, I authorise The Pharmacy Guild of Australia, South Australian Branch to collect, use and disclose my personal information for the following purposes:
For administrative and marketing purposes; to provide me with (free of charge) direct marketing communications that may be of interest to me; to provide me with Guild publications; for the purpose of lodging a complaint against the Government or Government agency (Federal, State or Territory); to comply with Government regulations regarding training programs or tax purposes; to draft legally binding agreements for Guild Programs; to be included on a National Database which may be disclosed to persons who have an interest in the DMMR Scheme including our National Secretariat; and to provide information to related Health Organisations for research and promotional purposes as requested.

I understand that the information contained in this form may be used by the organisation to manage the personal information it holds about me. I am also aware that I can gain access to my information and that my information may be disclosed to the organisations/people identified above.

I understand that I can express a wish not to receive any direct marketing information and that I can withdraw my consent at any time. I am aware that if I do decide to withdraw my consent to the collections, uses or disclosures that I have authorised on this form, I need to notify the organisation in writing. I also understand that I can access the Guild's Privacy Policy on the web site www.guild.org.au

☐ I do not authorise The Pharmacy Guild of Australia to use the personal information included on this form for the purposes of providing member services to me and for related direct marketing purposes.