Application for Membership

**SOLE PROPRIETOR – FORM 1 (RULE 29)**

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| --- |
| 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; 40 Burwood Road, Hawthorn VIC 3122; or fax 03 9819 2542. 3. Your application will be processed, invoiced for membership, and then ratified at the next meeting of the Victoria Branch Committee. Should you have any queries prior to this, please contact the Branch Office on 03 9810 9999. |

The Branch Director

The Pharmacy Guild of Australia, Victoria Branch

I, being an employer and eligible for Membership, hereby apply for admission to Membership of the Guild and upon election and while a member of the Guild agree 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 thereafter 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 or Resolutions.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Title:  Mr  Mrs  Miss  Ms  Other: | | Surname: | | |
| First name: | | Middle name: | Preferred name: | |
| Male  Female | Date of birth: | Private email: | | |
| Private address: | | Suburb: | State: | Postcode: |
| Postal address *(if different)*: | | 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. | | | | |

**BUSINESS DETAILS OF PHARMACY APPLYING FOR MEMBERSHIP**

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

**BUSINESS DETAILS OF OTHER PHARMACIES OWNED BY APPLICANT**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Pharmacy name: | | | | | | | Suburb: |
| Please indicate ownership type: | Company | Partnership | | Sole Proprietor | PBS Approval #: | | Is this pharmacy a  Guild Member?:  Yes  No |
| Prop 1: | | | Prop 2: | | | Prop 3: | |
| Prop 4: | | | Prop 5: | | | Prop 6: | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Pharmacy name: | | | | | | | Suburb: |
| Please indicate ownership type: | Company | Partnership | | Sole Proprietor | PBS Approval #: | | Is this pharmacy a  Guild Member?:  Yes  No |
| Prop 1: | | | Prop 2: | | | Prop 3: | |
| Prop 4: | | | Prop 5: | | | Prop 6: | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Pharmacy name: | | | | | | | Suburb: |
| Please indicate ownership type: | Company | Partnership | | Sole Proprietor | PBS Approval #: | | Is this pharmacy a  Guild Member?:  Yes  No |
| Prop 1: | | | Prop 2: | | | Prop 3: | |
| Prop 4: | | | Prop 5: | | | Prop 6: | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Pharmacy name: | | | | | | | Suburb: |
| Please indicate ownership type: | Company | Partnership | | Sole Proprietor | PBS Approval #: | | Is this pharmacy a  Guild Member?:  Yes  No |
| Prop 1: | | | Prop 2: | | | Prop 3: | |
| Prop 4: | | | Prop 5: | | | Prop 6: | |

*(if more, please attach separate list)*

**PLEASE COMPLETE ALL OTHER DETAILS ON NEXT PAGE**

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.

Signature:………………………………………………………………………………………………………………… Date: ……………………

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.

Return this declaration with the fee payable namely $…………………

**PRIVACY NOTICE**

I understand that the information contained in this form may be used by the organisation to manage the personal information it holds about me and may send me marketing material about their products, services and events, either directly or via their subsidiary companies.  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 collection, use or disclosure 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](http://beta.guild.org.au/content.asp?ID=685)

**OFFICE USE**

|  |  |  |  |
| --- | --- | --- | --- |
| Membership #: | Letter sent:   /    / 20 | Entered: Pharma360    /    / 20 | Entered: BIS    /    / 20 |
| Invoice #: | Inv date:    /    / 20 | Inv amount:$ | Notes: |