Application for Membership

**PARTNERSHIP – FORM 3 (RULE 29)**

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| Notes to consider when completing this form1. 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.
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The Branch Director

The Pharmacy Guild of Australia, Victoria Branch

We, the undersigned being employers and eligible for Membership and being all of the Partners in the partnership conducting the business of a pharmacist at:

|  |  |
| --- | --- |
| 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:       |

Hereby apply for admission of the partnership as a member of the Guild and upon election and while the partnership is 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 levies or other money payable from time to time as a member of the Guild pursuant to such Constitution or Resolutions.

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|  DETAILS OF ALL PARTNERS WITHIN THIS PHARMACY

|  |  |
| --- | --- |
| 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. |

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

|  |  |
| --- | --- |
| 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. |

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

|  |  |
| --- | --- |
| 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. |

 **Signature:…………………………………………………………………………………………… Date: ……………………** |

*(if more, please attach separate list)*

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

**DETAILS OF OTHER PHARMACIES OWNED EITHER INDIVIDUALLY, BY THE PARTNERSHIP OR IN WHICH THE PARTNERSHIP HAS A FINANCIAL 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:       |

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| --- | --- |
| Pharmacy name:       | Suburb:       |
| Prop 1:       | Prop 2:       | Prop 3:       |
| Prop 4:       | Prop 5:       | Prop 6:       |

*(if more, please attach separate list)*

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.

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 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.

**STATUTORY DECLARATION**

DECLARED AT ……………………………………………………) ………………………………………………………………………………………

THIS …………………………………………………… DAY OF ) Before me

…………………………………………………………………20……) ………………………………………………………………………………………

 A Person Duly Authorised To Witness Statutory Declarations

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: |