



# Application for Membership

## SOLE PROPRIETOR – FORM 1 (RULE 29)

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  Other \_\_\_\_\_

Date of birth \_\_\_\_\_ Private phone \_\_\_\_\_

Mobile phone \_\_\_\_\_ Private email \_\_\_\_\_

Private address \_\_\_\_\_

Postal address (if different) \_\_\_\_\_

I declare that I am 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.  Yes  No

## DETAILS OF PHARMACY APPLYING FOR MEMBERSHIP

Pharmacy name \_\_\_\_\_ PBS Approval Number \_\_\_\_\_

Pharmacy street address \_\_\_\_\_

Pharmacy postal name & address (if different) \_\_\_\_\_

Pharmacy email \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Banner name \_\_\_\_\_ Marketing group \_\_\_\_\_

Is this pharmacy a new pharmacy or has it been acquired?  NEW  ACQUIRED

Date pharmacy purchased \_\_\_\_\_ Date pharmacy 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 No. \_\_\_\_\_

Is this pharmacy a Guild Member?:  Yes  No

Proprietor 1 \_\_\_\_\_ Proprietor 2 \_\_\_\_\_ Proprietor 3 \_\_\_\_\_

Proprietor 4 \_\_\_\_\_ Proprietor 5 \_\_\_\_\_ Proprietor 6 \_\_\_\_\_

Pharmacy name \_\_\_\_\_ Suburb \_\_\_\_\_

Please indicate ownership type:  Company  Partnership  Sole Proprietor PBS Approval No. \_\_\_\_\_

Is this pharmacy a Guild Member?:  Yes  No

Proprietor 1 \_\_\_\_\_ Proprietor 2 \_\_\_\_\_ Proprietor 3 \_\_\_\_\_

Proprietor 4 \_\_\_\_\_ Proprietor 5 \_\_\_\_\_ Proprietor 6 \_\_\_\_\_

Pharmacy name \_\_\_\_\_ Suburb \_\_\_\_\_

Please indicate ownership type:  Company  Partnership  Sole Proprietor PBS Approval No. \_\_\_\_\_

Is this pharmacy a Guild Member?:  Yes  No

Proprietor 1 \_\_\_\_\_ Proprietor 2 \_\_\_\_\_ Proprietor 3 \_\_\_\_\_

Proprietor 4 \_\_\_\_\_ Proprietor 5 \_\_\_\_\_ Proprietor 6 \_\_\_\_\_



Pharmacy name \_\_\_\_\_ Suburb \_\_\_\_\_

Please indicate ownership type:  Company  Partnership  Sole Proprietor      PBS Approval No. \_\_\_\_\_

Is this pharmacy a Guild Member?:  Yes  No

Proprietor 1 \_\_\_\_\_ Proprietor 2 \_\_\_\_\_ Proprietor 3 \_\_\_\_\_

Proprietor 4 \_\_\_\_\_ Proprietor 5 \_\_\_\_\_ Proprietor 6 \_\_\_\_\_

Pharmacy name \_\_\_\_\_ Suburb \_\_\_\_\_

Please indicate ownership type:  Company  Partnership  Sole Proprietor      PBS Approval No. \_\_\_\_\_

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Pharmacy name \_\_\_\_\_ Suburb \_\_\_\_\_

Please indicate ownership type:  Company  Partnership  Sole Proprietor      PBS Approval No. \_\_\_\_\_

Is this pharmacy a Guild Member?:  Yes  No

Proprietor 1 \_\_\_\_\_ Proprietor 2 \_\_\_\_\_ Proprietor 3 \_\_\_\_\_

Proprietor 4 \_\_\_\_\_ Proprietor 5 \_\_\_\_\_ Proprietor 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.

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.

**PLEASE RETURN YOUR COMPLETED APPLICATION TO THE VICTORIAN BRANCH**  
**EMAIL** membership@vic.guild.org.au **POST** The Pharmacy Guild, 40 Burwood Road, Hawthorn VIC 3122

**PRIVACY COLLECTION NOTICE**

By submitting this completed application Form, you acknowledge that your personal information including your name, address, phone number and email address (Personal Information) is being provided to The Pharmacy Guild of Australia, Victoria, ABN 35 603 508 734 (Branch). The Personal Information you provide will be used by the Branch to administer and manage your membership, and to keep you informed about developments in the practice of pharmacy, and to send you marketing material about associated products, offers, services and events relating to community pharmacy (Services). The Branch is a branch of The Pharmacy Guild of Australia ABN 84 519 669 143 (the Guild) and, as such, may disclose your Personal Information to the Guild's National Secretariat, to other branches of the Guild, to the Guild's and the Branch's related bodies corporate, and to agents, contractors service providers and partners engaged by the Branch or the Guild to provide the Services. The Branch will not otherwise use or disclose your Personal Information, unless you have given consent, or the Branch is authorised or required to do so by law. For more information about how the Branch and the Guild handles your Personal Information, how you can request to access, correct or update the Personal Information the Branch holds about you, and who to contact if you have a privacy enquiry or complaint, please see the Guild's Privacy Policy on the website www.guild.org.au. If you elect not to provide your consent to any or all of the uses or disclosures of your Personal Information proposed in this Form, we may be unable to process your membership application and/or provide the Services to you. You can also withdraw your consent at any time, by just letting us know.