

**IDF Australia Division**  
**Professional Membership Application Form**

**Contact Details:**

|                        |  |
|------------------------|--|
| <b>Name:</b>           |  |
| <b>Title:</b>          |  |
| <b>Address:</b>        |  |
| <b>Telephone:</b>      |  |
| <b>Fax:</b>            |  |
| <b>E-mail Address:</b> |  |

**Background – Please tell us about your interest and involvement with PID.**

**Your professional qualifications and training:**

**If you are a clinician please give details of your current practice.**

*(Continue on the back if you wish to add any further information)*

I (*name*).....give IDFA permission to release my name and details to staff / IDFA Medical panel in order to enable full participation and support by the Foundation.

Date;.....

Signature: .....

Please return the completed form to: IDF Australia Registration, PO Box 198, Villawood. NSW 2163  
Or Fax toll free to: 1800 033 603