



**Western Australian Centre for Remote and Rural Medicine Limited  
T/A Rural Health West**

**APPLICATION FOR ASSOCIATE MEMBERSHIP**

To: Rural Health West  
PO Box 433  
NEDLANDS WA 6909

**Nominee:**

I apply for associate membership of the Western Australian Centre for Remote and Rural Medicine Limited (WACRRM).

TITLE: \_\_\_\_\_

FULL NAME: \_\_\_\_\_

ADDRESS FOR CORRESPONDENCE: \_\_\_\_\_

Suburb/City: \_\_\_\_\_ State: \_\_\_\_\_ Post Code: \_\_\_\_\_

TELEPHONE: Work: \_\_\_\_\_ Home: \_\_\_\_\_ Mobile \_\_\_\_\_

I agree to abide by the terms of the company Constitution, in particular Rule 20.

I attach a statement of 200 words or less setting out my qualifications and experience.

\_\_\_\_\_

*Date* / /

Signature of Applicant

