APPLICATION FORM
COSMETIC MEDICAL TRAINING PROGRAM

Surname:	First Name(s):	
Date of Birth:		
Principal Practice Address:		
Suburb:	State:	Post Code:
Postal Address:		
Suburb:	State:	Post Code:
Other Locations (Practice or Postal)		
Suburb:	State:	Post Code:
Contact Telephone Numbers:	Principal Work:	( )
	Mobile:	
	Home:	( )
Email Contact:		

University of Graduation:	Year:
Qualifications/Post-graduate Degrees/Diplomas:	

Countries of Medical Registration: (please tick)		
( ) Australia	( ) New Zealand	Other:
Registration No.:		
Please list any restrictions or conditions imposed		
Any medical litigation, disciplinary action or investigation by Medical Boards:		Yes or No (if yes, please provide details in separate communication for confidentiality)

Memberships:	( ) Australian Medical Association
(please tick)	( ) CPSA
	( ) AMSA
	( ) International Society of Cosmetic Laser Surgeons
	( ) American Society for Lasers in Medicine
Others:	

Indemnity Insurance Company:
Indemnity Insurance Policy No: (please attach copy)

Other Training - (Summary Only - full details in CV)

Accompanying Documentation (Checklist)	
1 Curriculum Vitae	This should contain a comprehensive outline of medical and surgical training
2 Copies of all Degrees/Diplomas are required in support of this application	
3 Medical Registration/Annual Practicing Certificate	
4 Medical Indemnity Evidence of cover	
5 $330.00 (Inc GST) For non-refundable administration costs.	Pay EFT – Westpac Banking Corporation BSB: 032-021, Acc: 134477, remittance to be emailed to admin@accsm.org.au Pay by credit card Type of Card: _____ Card No: _____ Expiry: _____

Completed applications should be sent to:

E: admin@accsm.org.au
P: Australasian College of Cosmetic Surgery and Medicine
   PO Box 36
   Parramatta NSW 2124

For Office Use Only:

Application received by:
Date:

Approved by   Signature

Date