ACCSM

AUSTRALASIAN COLLEGE
OF COSMETIC SURGERY AND MEDICINE

APPLICATION FORM
SURGICAL REGISTRAR 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:	( )	
	Principal Fax:	( )	
	Mobile:		
	Home:	( )	
Email Contact:			

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

Countries of Medical Registration: (please tick) ( ) Australia Registration No.:	( ) New Zealand	Other:
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: (please tick)	( ) Australian Medical Association
	( ) American Academy of Cosmetic Surgery
	( ) 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)

Current Hospital Accreditations for Operating Privileges

1
2
3
4
5
6

Surgical 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	Certified 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: _____ Pay by cheque, make cheques payable to the Australasian College of Cosmetic Surgery and Medicine

Completed applications should be sent to:

admin@accsm.org.au
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