PAYROLL DEDUCTION AUTHORITY

THE QUEENSLAND BRANCH OF
AUSTRALIAN MEDICAL ASSOCIATION

ABN 17 009 660 280

AMA QUEENSLAND

I WISH TO PAY BY AMA QUEENSLAND MEMBERSHIP FEES BY PAYROLL DEDUCTION

PERSONAL DETAILS

AMA Queensland membership number: _____

Given names: _____ Surname: _____

Address: _____

City: _____ State: QLD Postcode: _____

EMPLOYMENT DETAILS

Hospital and Health Service: _____

My payroll number: _____

I, surname: _____ Given names: _____

I authorise Queensland Health to continue to deduct from my salary the sum of $_____ per fortnight and continue for each subsequent year and pay such sum to The Queensland Branch of Australian Medical Association with ABN 17 009 660 280 (AMA Queensland). I authorise you to accept and act upon any advice from AMA Queensland that the amount of AMA Queensland subscription or the rate of deduction payable by me has been altered in accordance with the Rules of AMA Queensland and that this authority shall extend to cover such alterations.

This authority shall be deemed to remain in full force and effect until written revocation thereof shall be given by me to AMA Queensland and to my employer. The receipt by the appropriate Officer of this authorisation shall be sufficient discharge to the employer for the payment of any amount so deducted by you. I authorise the providing of information to AMA Queensland of alteration to details provided on this form for employment and related interests in accordance with the Information Privacy Act 2009 (Qld).

Signature of applicant: _____ Date: _____

CONTACT DETAILS

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